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Supreme Court, U.S.
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In The

Supreme Court of the United States

JINDAL UNITED STEEL CORP.
and SAW PIPES USA, INC.,

Petitioners,

v.

ELAINE CHAO, SECRETARY, DEPARTMENT OF LABOR and OCCUPATIONAL SAFETY AND HEALTH COMMISSION,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

I. Despite the Occupational Safety and Health Review Commission's statutory authority to affirm, modify or vacate the Secretary of Labor's proposed penalties, *see* 28 U.S.C. § 659(c), must the Commission accept the Secretary's proposals and assess penalties that it has concluded, after an evidentiary hearing, are not supported by fact?

II. Despite its statutory mandate to assess penalties, *see* 28 U.S.C. § 666(j), and its longstanding, heretofore unquestioned practice of grouping related violations into a single violation for penalty purposes, does the Occupational Safety and Health Review Commission no longer have the authority to group willful violations for penalty purposes when the Secretary of Labor has made the unreviewed decision to cite such violations on an individual, "per instance," basis in order to increase the amount of a potential penalty?

PARTIES TO THE PROCEEDING

1. Jindal United Steel Corp., Petitioner

2. Saw Pipes USA, Inc., Petitioner

3. Elaine Chao, Secretary of Labor, Respondent

4. Occupational Safety and Health Review Commission, Ray H. Darling, Executive Secretary

CORPORATE DISCLOSURE STATEMENT

In accordance with Sup. Ct. R. 29.6, Petitioners state that Jindal United Steel Corp. has no parent corporation. No public corporation owns ten percent or more of Jindal United Steel Corp.'s common stock.

Saw Pipes USA, Inc., has no parent corporation. Jindal Saw Limited, a publicly traded company in India, owns more than ten percent of the common stock of Saw Pipes USA, Inc.

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PETITION FOR A WRIT OF CERTIORARI

The petitioners respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The order and opinion of the United States Court of Appeals for the Fifth Circuit is reported at *Chao v. Occupational Safety and Health Review Commission*, 480 F.3d 320 (5th Cir. 2007). App. 1.

The Occupational Safety and Health Review Commission's decisions are reported at *Secretary of Labor v. Saw Pipes USA, Inc.*, 21 O.S.H. Cas. (BNA) 1306, App. 10-19, and *Secretary of Labor v. Jindal United Steel Corp.*, 21 O.S.H. Cas. (BNA) 1298, 2005 O.S.H.D. (CCH) P 32856, App. 20-40. The decisions by the Commission's Administrative Law Judge are reported at *Secretary of Labor v. Saw Pipes USA, Inc.*, 2002 O.S.H.D. (CCH) P 32580, App. 41-78, and *Secretary of Labor v. Jindal United Steel Corp.*, 2001 O.S.H.D. (CCH) P 32528, App. 79-138.

JURISDICTION

The order and opinion by the United States Court of Appeals for the Fifth Circuit was entered on February 21, 2007. App. 9. The order denying Petitioners' petitions for panel rehearing and rehearing en banc were entered April 30, 2007. App. 139-40. 28 U.S.C. § 1254(1) confers jurisdiction on this Court.

STATUTORY PROVISIONS INVOLVED IN THE CASE

29 U.S.C. § 658(a) states:

> If, upon inspection or investigation, the Secretary or his authorized representative believes that an employer has violated a requirement of section 654 of this title, of an standard, rule, or order promulgated pursuant to section 655 of this title, or of any regulations prescribed pursuant to this chapter, he shall with reasonable promptness issue a citation to the employer. Each citation shall be in writing and shall describe with particularity the nature of the violation, including a reference to the provision of the chapter, standard, rule, regulation, or order alleged to have been violated. In addition, the citation shall fix a reasonable time for the abatement of the violation. The Secretary may prescribe procedures for the issuance of a notice in lieu of a citation with respect to de minimus violations which have no direct or immediate relationship to safety or health.

29 U.S.C. § 659(c) states:

> If an employer notifies the Secretary that he intends to contest a citation issued under section 658(a) of this title or notification issued under subsection (a) or (b) of this section, or if, within fifteen working days of the issuance of a citation under section 658(a) of this title, any employee or representative of employees files a notice with the Secretary alleging that the period of time fixed in the citation for the abatement of the violation is unreasonable, the Secretary shall immediately advise the Commission of such notification for a hearing (in accordance with section 554 of

> Title 5 but without regard to subsection (a)(3) of such section). The Commission shall thereafter issue an order, based on findings of fact, affirming, modifying, or vacating the Secretary's citation or proposed penalty, or directing other appropriate relief, and such order shall become final thirty days after its issuance. . . .

29 U.S.C. § 666(a) states:

> Any employer who willfully or repeatedly violates the requirements of section 654 of this title, standard, rule, or order promulgated pursuant to section 655 of this title, or regulations prescribed pursuant to this chapter may be assessed a civil penalty of not more than $70,000 for each violation, but not less than $5,000 for each violation.

29 U.S.C. § 666(j) states:

> The Commission shall have authority to assess all civil penalties provided in this section, giving due consideration to the appropriateness of the penalty with respect to the size of the business of the employer being charged, the gravity of the violation, the good faith of the employer, and the history of prior violations.

STATEMENT OF THE CASE

The Fifth Circuit decision has disrupted the balance of power between the Secretary of Labor ("Secretary") and the Occupational Safety and Health Review Commission ("Commission") that Congress established through the Occupational Safety and Health Act (the "OSH Act"). The decision ignores the OSH Act's grant of penalty-setting authority to the Commission and gives the Secretary

unchecked, de facto penalty-setting power. As a result, the Commission's heretofore unquestioned, statutory authority to act in an adjudicative role and "affirm, modify or vacate" the Secretary's proposed citations by grouping related, willful violations for penalty purposes has been abrogated. If allowed to stand, the decision would establish an enforcement regime in the Fifth Circuit through which penalties are effectively assessed by the Secretary, rather than by the Commission after a full and fair administrative trial at which all parties may present evidence. This outcome flouts Congressional intent, is anathema to fundamental balance-of-power principles and contravenes the precedent of other Circuits.

1. In the Administrative Context, a Strict Separation of Powers Is Necessary to Ensure Fairness.

It has long been recognized that within the administrative context, the commingling of the executive function of prosecution with the judicial function of adjudication creates problems of fairness. In the debate preceding the 1946 Administrative Procedures Act ("APA"), Congress emphasized the risks inherent in a system where a prosecutor participating in adjudication would rely upon untested perceptions and information not adduced in an adversarial hearing, and thereby not introduced via sworn testimony that is subject to rebuttal and cross-examination. S. DOC. NO. 77-8, at 56 (1941).

The APA accommodates this concern in two ways. First, it requires that administrative law judges responsible for conducting adjudicative hearings be insulated from the prosecutorial process. *See* 5 U.S.C. § 556(b) (1994) (providing for an administrative law judge to preside at

the taking of evidence in agency adjudications). Second, no official of the agency who had a role in investigating or prosecuting the case can participate or advise in the agency's adjudicative review or decision in the case. *See* 5 U.S.C. § 554(d) (1994) ("[a]n employee or agent engaged in the performance of investigative or prosecuting functions . . . may not . . . participate or advise in the decision, recommended decision, or agency review pursuant to section 557 of this title. . . .").

2. Through the OSH Act, Congress Established a Separation of Powers That is Even More Stringent than the APA.

In enacting the OSH Act, Congress instituted procedural protections that go even further than those of the APA. The Act strictly separates enforcement and adjudicative powers between the Secretary and the independent, presidentially-appointed Commission. In keeping with this separation of powers, the OSH Act vests the Secretary with the authority to issue initial citations and to propose penalties, while the Commission has the exclusive authority to issue an order "affirming, modifying, or vacating the Secretary's citation or proposed penalty, or directing other appropriate relief." 29 U.S.C. §§ 658(a); 659(c). This structure of checks and balances between the Secretary and the Commission was intended to "accord [even more closely] with traditional notions of due process" than the traditional unitary agency model. 116 CONG.REC. 36,532 (1970) (statement of Senator Javits); *Martin v. OSHRC*, 499 U.S. 144, 151 (1991).

3. Congress Has Mandated that the Commission Have Ultimate Penalty-Setting Authority.

Under the OSH Act, the Secretary promulgates regulations and issues citations and proposed penalties for perceived violations of the OSH Act. 29 U.S.C. § 658(a). However, if an employer contests the citation or proposed penalty, final penalties can only be assessed by the Commission after a full hearing in accordance with 5 U.S.C. § 554. 29 U.S.C. § 659(c).

4. Through Her Internal, Unreviewed "Per Instance" Charging Guideline, the Secretary Attempts to Control the Penalty-Setting Process.

The Secretary has an internal, "per instance" penalty charging guideline which she uses in order to determine the penalties that she will propose. Proposed, "per instance" penalties are issued prior to any judicial review and are means by which the Secretary seeks to increase the total proposed penalty in a case.[1] "Per instance" penalties deviate from the Secretary's usual practice of assessing a single, proposed penalty for violations of the same

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[1] OSHA's directive regarding the policy makes this clear:

> Over the past several years, in a limited number of cases OSHA has alleged a separate violation and proposed a separate penalty for each instance of noncompliance with OSHA recordkeeping regulations, with the safety and health standards, and with the General Duty Clause. . . . The resulting large aggregate penalties are part of a compliance strategy which improves the efficiency and effectiveness of the agency and conserves its limited resources.

See OCCUPATIONAL SAFETY & HEALTH ADMINISTRATION INSTRUCTION CPL 2.80, HANDLING OF CASES TO BE PROPOSED FOR VIOLATION-BY-VIOLATION PENALTIES (1990) (hereinafter "CPL") *at* 2.80(G). App. 141-68.

regulation.[2] "Per instance" penalties seek individual penalties for every single occurrence of a violation in order to increase the total potential penalty.[3] App. 145. For instance, if an employer's single policy resulted in 100 incorrect record-keeping entries, the Secretary could apply her "per instance" guideline and seek 100 separate penalties – instead of just one – for the violations that arose out of that policy. According to the Secretary's guidelines, her decision to cite on a "per instance" basis should rest on two factors: (1) whether the conduct at issue was willful; and (2) whether, in the Secretary's unreviewed opinion, the violation was a "high gravity" willful violation. App. 147-49. In this case, the Secretary claims that her decision to classify a violation as "high gravity" and to apply her "per instance" charging guideline is not subject to judicial review. Accordingly, she lays claim to a unilateral, unchecked authority to make a final determination about the magnitude of a violation without having to subject her evidence or theories to judicial proof.

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[2] "Violations of a single standard having the same classification found during the inspection of the establishment or worksite generally shall be combined into one alleged citation item." OCCUPATIONAL SAFETY & HEALTH ADMINISTRATION, FIELD INSPECTION REFERENCE MANUAL (1994), *at* III.5.a. The manual specifically states that violations of recordkeeping requirements normally should be grouped as a single violation. *Id.* at III.5.b(4).

[3] The Secretary's ability to cite violations individually is limited "to those standards which are capable of such interpretation." *Sec'y of Labor v. Hartford Roofing Co., Inc.*, 1995 WL 555498 at *6 (O.S.H.R.C.).

5. Through the Practice of Grouping, the Commission Has Long Exercised Its Penalty Assessment Authority and Acted As a Check on the Secretary's Unreviewed Charging Decisions.

The Commission long has used its statutory authority to modify the Secretary's proposed citations and to "direct[] other appropriate relief" by grouping related citations that the Secretary elected to issue on a "per instance" basis. *See, e.g., Mica Corp. v. OSHRC*, 295 F.3d 447, 449 (5th Cir. 2002) (per curiam) (noting that the ALJ had combined two citations "for purposes of assessing a single penalty" and that the Commission had declined to review the ALJ's decision); *Dakota Underground, Inc. v. Sec'y of Labor*, 200 F.3d 564, 569 (8th Cir. 2000) ("[i]n its discretion, the Review Commission sometimes groups violations together even when the Secretary proposes multiple penalties"); *Hackensack Steel Corp.*, 20 O.S.H. Cas. (BNA) 1387, 2003 WL 22232017 at *10 (the Commission "may assess penalties for distinct but potentially overlapping violations and may find it appropriate to assess a single penalty for such violations"); *H.H. Hall Constr. Co.*, 10 O.S.H. Cas. (BNA) 1042, 1981 WL 18913 at *4 ("[the] Commission has wide discretion in the assessment of penalties for distinct but overlapping violations and it is appropriate to assess a single penalty for overlapping violations as the Commission has done in the past"). This case is the first known instance in which the Secretary has disputed the Commission's well-established "grouping" prerogative. In doing so, she has attempted to abrogate the Commission's longstanding authority to act as a check on the Secretary's unreviewed penalty proposals.

6. The Case At Issue: The Secretary Proposes Per-Instance Penalties Against Jindal and Saw Pipes for a Single Practice that Results in Recordkeeping Violations.

Upon inspection of facilities belonging to Jindal United Steel Corporation ("Jindal") and Saw Pipes USA ("Saw Pipes"),[4] the Secretary concluded that they had violated the OSH Act's recordkeeping regulation, 29 C.F.R. §1904.2, through a shared policy of misclassifying which injuries had to be reported to the Occupational Safety and Health Administration ("OSHA"). The violations arose from a single practice through which the companies failed to record certain injuries to temporary workers and injuries for which no time was lost from work. App. 43, 83. Despite the non-serious nature of these offenses, the Secretary applied her internal "per-instance" penalty charging policy in the attempt to increase the amount of an ultimate penalty. Accordingly, she proposed separate penalties for every single time that a recordable injury was not included in the companies' OSHA logs – even for instances in which the injuries that went unrecorded were minor bug bites, contusions and abrasions that did not result in lost work time. App. 74-75, 133. In total, the Secretary sought an aggregate penalty of $1,062,000 against Jindal and $536,000 against Saw Pipes. The companies contested the citations.

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[4] Jindal and Saw Pipes are located on a common tract of land and share common ownership and some managerial personnel. Saw Pipes holds stock in Jindal.

7. The Commission Determined That the Secretary's Proposed Penalties Were Unsupported By the Evidence and Grossly Inappropriate to the Scope of the Violations.

The Commission, through its administrative law judge ("ALJ"), conducted hearings at which the Secretary argued that Jindal and Saw Pipes had a single pattern and practice of willful non-reporting, but that the single practice should result in multiple, "per instance" penalties. The ALJ concluded that 82 "willful" recordkeeping violations had taken place at Jindal, and 59 at Saw Pipes. App. 77-78, 136-38. However, he determined that the Secretary's proposed penalties were "inappropriate regardless of how [they were] derived." App. 133. Therefore, he modified the Jindal citation as follows:

> [I]n proposing a total recordkeeping penalty of over $1,000,000 the Secretary overstates the gravity of [the] violations. Even under the Secretary's theory of the case, Respondent reported major injuries to Workers' Compensation as well as to OSHA while only the more marginal, or less serious injuries went unreported. . . .
>
> . . . Taking into account Jindal's size, over 250 employees, the very low gravity of the violations, and the absence of any evidence of prior OSHA inspections . . . , this judge finds that a penalty of $70,000 is appropriate.
>
> . . . To effectuate the penalty, all willful items are grouped under one willful violation and assessed the maximum penalty of $70,000.

App. 133-35.

The ALJ reached a similar conclusion after considering the evidence that the Secretary relied upon for the Saw Pipes citations:

> [The Secretary's] departure from grouping similar violations result[ed] in an aggregate penalty that [was] disproportionate to the violation and overstates its gravity. The record demonstrates that [the Secretary] did not base the gravity of Saw [Pipes'] under-reporting on the severity of the actual unreported injuries, which consist[ed] mainly of minor burns, contusions and foreign bodies in the eye.
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> * * *
>
> In addition, at the hearing [the Secretary] advanced the theory that Saw [Pipes] engaged in a single pattern and practice of willful non-reporting. . . . [She] made no attempt to prove that Saw [Pipes] willfully failed to record each individual injury. The evidentiary path chosen by [the Secretary] was considerably less onerous than showing willfulness in each and every instance. While choosing to make a single showing of a pattern and practice of under-reporting, [the Secretary] nevertheless [sought] to have each instance of under-reporting assessed individually, as though she had proved that Saw [Pipes] possessed a willful state of mind in each instance. . . . a more appropriate penalty would be reached by grouping all record-keeping instances into a single violation with a single [$70,000] penalty.

App. 75-76.

The parties petitioned the full Commission to review the ALJ's decisions. The two Commissioners were divided

on the ALJ's decision to group the violations, and the Secretary subsequently sought Fifth Circuit review.[5]

8. The Fifth Circuit's Decision Fundamentally Alters the Congressionally-Established Checks and Balances Between the Secretary and the Commission.

In a panel decision on February 21, 2007, the Fifth Circuit vacated and remanded the Commission's penalty assessment. Concluding that 29 U.S.C. § 666(a) was "a limitation on the Commission's authority to assess penalties," the court determined that the Commission was obligated to assess penalties of at least $5,000 per willful violation if the Secretary chose to charge on a "per instance" basis. App. 6-7. The court's opinion made no mention of 29 U.S.C. § 659(c) which allows the Commission to "affirm[], modify[], or vacat[e]" the Secretary's charging decisions, "based on findings of fact." Instead, it held that the decision of whether to group violations for penalty purposes rested solely with the Secretary, as "the Secretary may group willful violations at the charging stage, whereas the Commission may not group per-instance willful violations at the penalty stage." App. 6.

The Fifth Circuit subsequently denied petitions by Jindal and Saw Pipes for rehearing and rehearing en banc. App. 139-40.

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[5] Because official action of the Commission requires an affirmative vote of two members, 29 U.S.C. § 661(f), the Commissioners vacated the direction for review, allowing the Fifth Circuit to directly review the ALJ decision.

REASONS FOR GRANTING THE WRIT

This case presents essential questions about checks-and-balances and due process under the OSHA Act and asks the Court to consider whether the Secretary's attempt to strip the Commission of its longstanding grouping practice is an enlargement of her power that gives her de facto penalty assessment authority in contravention of the OSH Act. This Court previously has been called upon to settle such "jurisdictional" disputes between the Secretary and the Commission arising from the OSH Act's split enforcement scheme, *see Martin v. OSHRC*, 499 U.S. 144 (1991), and its guidance is urgently necessary here. The Fifth Circuit's overly restrictive interpretation of the Commission's adjudicative authority disregards the express language of the OSH Act, threatens the due process Congress ensured for employers through the OSH Act, conflicts in principle with the holdings of three other circuits, and distorts this Court's holding in *Cuyahoga Valley Ry. Co. v. United Transp. Union*, 474 U.S. 3 (1985).

I. The Fifth Circuit Incorrectly Decided a Critical Issue Regarding the Balance of Power Between the Secretary and the Commission that Has Not Been, But Should Be, Decided By This Court.

A. The Decision Effectively Grants Unreviewable Penalty Assessment Authority to the Secretary.

This case has wide-reaching implications for every employer in the Fifth Circuit subject to the OSH Act. It effectively transforms the Secretary's charging authority into a de facto penalty assessment authority, as her unreviewable decision of whether or not to group willful

violations will establish minimum penalties far above the minimums established by the OSH Act – even when, as here, the ALJ determines after an evidentiary hearing that the penalty is grossly disproportionate to the proven facts. An unpredictable,[6] and costly, enforcement scheme will exist in which true penalty-setting power rests with the Secretary instead of a neutral ALJ who assesses penalties only after a full hearing and briefing. Employers will face the Hobson's choice of settling expensive citations of dubious merit, or incurring the costs of trial with the risk that an ultimate penalty cannot reflect the true gravity of a violation.

B. The Fifth Circuit's Interpretation of the OSH Act as Giving the Secretary Unchecked Penalty-Setting Authority Warrants Review By This Court.

The Fifth Circuit decision is based on the assumption that the Secretary's decision to deviate from the standard procedure of citing a practice that results in infractions of

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[6] For example, in November 2005 the Secretary alleged that a Maine employer failed to record injuries in 59 instances, failed to record injuries promptly in 77 instances, and erroneously certified annual injury and illness summaries as being complete twice. However, she only issued three willful citations for $165,000 in fines. *See* Press Release, Occupational Safety and Health Administration Region 1 (November 21, 2005) (available at www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=11696). In January 2007 she issued a Massachusetts-based employer only two willful citations for 84 alleged record-keeping failures. *See* Press Release, Occupational Safety and Health Administration Region 4 (January 22, 2007) (available at www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=13539). It is unclear why the Secretary sought fines under $200,000 in those cases and in excess of a million dollars here – but according to her, she need not explain any disparities.

the same standard as a single violation is an unreviewable matter of her "prosecutorial discretion." In reaching this conclusion, the court ignored significant provisions of the OSH Act,[7] – despite the elemental rule of statutory construction that a statute should be read as a harmonious whole, with its various parts being interpreted within their broader statutory context.[8] The Fifth Circuit's failure to consider the Commission's statutory authority to "modify[] . . . the Secretary's citation or proposed penalty" or "direct[] other appropriate relief," 29 U.S.C. § 659(c), resulted in a mischaracterization of the Secretary's "prosecutorial discretion" as unreviewable.

As this Court has emphasized, the Commission has an adjudicative function. *Martin v. OSHRC*, 499 U.S. 144, 154 (1991). 29 U.S.C. § 659(c) grants the Commission significant latitude in exercising that adjudicative authority.

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[7] The court's analysis focused only on 29 U.S.C. § 666(a), which states that an employer who willfully or repeatedly violates an OSH Act standard "may be assessed a civil penalty of not more than $70,000 for each violation, but not less than $5,000 for each willful violation." Because the provision refers to "each violation," the Fifth Circuit concluded, once the Secretary issues an instance-by-instance citation for related violations of a standard, the Commission lacks the authority to group the related violations for penalty purposes and assess a single penalty between $5,000 and $70,000, even if it finds that the offenses are low-gravity and do not warrant application of the egregious penalty policy. App. 4-8.

[8] Chief Justice Taney explained long ago that, "[i]n expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." *United States v. Boisdore's Heirs*, 49 U.S. 113, 122 (1850). More recently, Justice Scalia noted that "[s]tatutory construction . . . is a holistic endeavor. A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme. . . ." *United Savings Ass'n v. Timbers of Inwood Forest Associates*, 484 U.S. 365, 371 (1988) (citations omitted).

First, it provides that the Commission may *modify* the Secretary's citations or penalty proposals. *Id.* To "modify" means "to make less severe."[9] OXFORD ENGLISH DICTIONARY (2d ed. 1989). In accordance with the statute's plain language, the Commission is authorized not only to make a proposed penalty "less severe," but also to make the Secretary's citation "less severe" where the facts so warrant.[10] 29 U.S.C. § 659(c). Therefore, the Commission's grouping of violations that could have been charged as a single violation is entirely within its statutory authority.

The Fifth Circuit mistakenly concluded that the Commission's power was limited to modifying the Secretary's proposed penalties. This logic wrongly assumes that the Secretary's decision to issue a citation on a grouped or "per instance" basis has no bearing on ultimate penalties. It also ignores the fact that the very purpose of charging on a "per instance" basis is to give the Secretary leverage by increasing the potential penalties that an employer faces. Further, the court's interpretation of the Commission's power would render the grant of authority in 29 U.S.C. § 659(c) to modify a "citation" as mere surplusage. This is an unreasonable result. *See Bailey v. United States*, 516 U.S. 137, 146 (1995) ("we assume that Congress used

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[9] In the absence of a statutory definition, "we construe a statutory term in accordance with its ordinary or natural meaning." *FDIC v. Meyer*, 510 U.S. 471, 476 (1994).

[10] For example, the Commission routinely affirms violations, but exercises its statutory authority to change a violation's level of severity from that charged by the Secretary. *See, e.g., Sec'y of Labor v. Dover Elevator Co.*, 1992 O.S.H.D. (CCH) P 29680 (O.S.H.R.C.A.L.J.); (downgrading serious citation to de minimus); *Sec'y of Labor v. Commercial Newspaper Serv.*, 19 O.S.H. Cas. 1363 (O.S.H.R.C.A.L.J. 2001) (reclassifying serious citation as "other than serious").

two terms because it intended each term to have a particular, nonsuperfluous meaning"). Additionally, the Commission has power to "direct[] other appropriate relief" – a broadly worded power referred to by one judge as the Commission's "residual remedial power." *See Reich v. OSHRC*, 998 F.2d 134, 143 (3d Cir. 1993) (Becker, J. dissenting). The Fifth Circuit did not consider 29 U.S.C. § 659(c) in reaching its conclusion, and it is impossible to reconcile the expansive language of that provision with the court's conclusion that the Commission must blindly accept the Secretary's charging decisions even when it concludes after a full evidentiary hearing that those decisions are unsupported by fact.

The result of the Fifth Circuit's decision is an undermining of the statutory requirement that the Commission has the sole "authority to assess all civil penalties." 29 U.S.C. § 666(j). If allowed to stand, the decision will give the Secretary carte blanche to assess penalties and effectively disregard the Commission's adjudicative role. This outcome runs counter to the intent behind the OSH Act, which was designed to ensure an adjudicative check on the Secretary and provide due process for employers. Under the Fifth Circuit decision, the Secretary will have de facto penalty-setting power. As in this case, the Secretary can decide whether to assess a penalty of $7,000 or $600,000 for the same violation, and the Commission could not override that whim or require the Secretary to justify it, regardless of what the evidence adduced at trial reflects.

The Commission long has exercised its authority to check the Secretary's penalties and citations through grouping. When Congress amended the OSH Act in 1990, Omnibus Budget Reconciliation Act of 1990, 104 Stat.

1388, it took no steps to remove the Commission's authority to do so.[11] *See Dir. of Revenue of Mo. v. CoBank, ACB*, 531 U.S. 316, 323 (2001) ("it would be surprising, indeed," if Congress had effected a "radical" change in the law "*sub silentio*"); *Reich v. OSHRC*, 998 F.2d 134, 139 (3d Cir. 1993) (finding it "significant" that "the Secretary did not take the opportunity to have Congress remove the Commission's authority to reclassify citations"). In fact, House and Senate conferees "note[d] that th[e] mandatory minimum level applies to *initial*, assessed penalties," not to final penalties as determined by an ALJ after an evidentiary hearing. H.R. REP. NO. 101-964 at 688 (1990) (Conf. Rep.) (emphasis added). Consistent with the Congressional silence, the Commission continued to group the Secretary's citations since the 1990 amendments. *See, e.g., C-Post*, 19 O.S.H. Cas. (BNA) 1457 (2001), 2001 WL 506921 at *6 n.1 ("[t]he Review Commission has wide discretion in assessing penalties and has the authority to group distinct but overlapping violations for the purpose of penalty assessment"). Nonetheless, the Fifth Circuit's decision concludes that congressional silence on the Commission's longstanding grouping practice when it amended the OSH Act in 1990 amounted to an abrogation of that practice. App. 7. That conclusion is supported by neither principles of statutory interpretation nor post-amendment Commission practice.

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[11] Congress' decision to establish a willful penalty floor was motivated by its belief that such a floor was necessary in light of inflation and that OSHA's enforcement efforts had fallen short of effective deterrence. H.R. REP. NO. 101-964 at 688 (1990) (Conf. Rep.).

C. The Fifth Circuit Decision Ignores the Enforcement Structure Established By Congress.

The Fifth Circuit's holding flouts the enforcement structure established by the OSH Act. As this Court has determined, the Commission – not the Secretary – is a "neutral arbiter" charged with "making authoritative findings of fact and with applying the Secretary's standards to those facts in making a decision." *Martin v. OSHRC*, 499 U.S. 144, 154 (1991). In keeping with that role, the ALJ here made findings of fact that the "per instance," egregious penalty policy applied by the Secretary was wholly inappropriate, particularly given the Secretary's "pattern and practice" theory of willfulness in which she did not even attempt to prove the willfulness of each cited violation. App. 75-76, 133-35. Yet the Fifth Circuit granted unchecked penalty-setting power to the Secretary, concluding that the decision of whether to assess penalties on a "grouped" or "per instance" basis is a "policy decision" that can only be made by the Secretary. App. 6.

Allowing the Secretary to make her so-called policy decision in an unreviewable vacuum, without allowing the Commission to apply the penalty guideline to the facts proven at trial, does nothing to further the policy behind the OSH Act, which created the Commission in an attempt to protect employers from unchecked decisions by the Secretary.[12] As the Secretary purportedly employs an

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[12] As one senator explained:

> The concentration of all authority for the promulgation of standards, the inspection and investigation of complaints, the prosecution of cases, and the adjudication of cases, totally in

(Continued on following page)

intensive screening process when determining whether to apply the policy, demonstrating its applicability should not be burdensome to her or impede the benefits of the per-instance penalty policy. *See* App. 160-67. The deterrence accomplished by the policy will not be diminished by acknowledging the Commission's authority to review its applicability. Therefore, it is apparent that the Commission's role as "arbiter" encompasses the duty to review the Secretary's per-instance penalty proposals and to modify her citations if the facts so warrant.

II. The Fifth Circuit Decision Adds to the Growing Circuit Split About the Interplay Between the Secretary's "Prosecutorial Discretion" and the Commission's Penalty-Setting Responsibility.

A. The Circuit Courts Are Divided About the Breadth of the Secretary's Prosecutorial Discretion.

The Fifth Circuit's decision perpetuates growing confusion about the relationship between the Secretary's "prosecutorial authority" and the Commission's adjudicative powers. The First, Third, and Ninth Circuits have all concluded that the authority to reclassify a violation charged by the Secretary rests squarely within the Commission's

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> the hands of the Secretary of Labor is not a balanced approach. It is this structure, this procedural mechanism, which is objectionable to me, and I believe objectionable to many people around the country. It is objectionable because concentration of power gives rise to a great potential for abuse. . . . The tradition of this Nation has been to place safeguards on power whenever it is granted. One of the greatest safeguards has been the separation of powers.

116 CONG.REC. S37,336 (1970) (STATEMENT OF SEN. DOMINICK).

statutory responsibility to modify and assess penalties. *See, e.g., Chao v. Symms Fruit Ranch*, 242 F.3d 894 (9th Cir. 2001); *Reich v. OSHRC*, 998 F.2d 134 (3d Cir. 1993); *Donovan v. Daniel Constr. Co., Inc.*, 692 F.2d 818 (1st Cir. 1982).

By contrast, the Fifth Circuit relied on *Caterpillar, Inc. v. Herman*, 136 F.3d 666 (7th Cir. 1997), in this instance for its conclusion that "the Commission must assess a penalty for all violations charged and proven." App. 8. The *Caterpillar* court reached this holding when considering the analogous issue of whether the Commission had the authority to affirm a violation cited by the Secretary, but label it as de minimus, and thus not requiring abatement. In *Caterpillar*, the Secretary successfully claimed that classifying a violation as de minimus was solely within her prosecutorial authority.

This dissension amongst the circuits indicates mounting uncertainty as to the interaction between 29 U.S.C. § 659(c)'s broad grant of adjudicative power and other provisions of the OSH Act, particularly as the Secretary advances increasingly aggressive interpretations.

In each reclassification case, the Secretary argued that the language of 29 U.S.C. § 658(a)[13] implied that only she could classify a violation as de minimus, just as she argues here that only she can decide that a per-instance penalty is appropriate. The Third Circuit rejected her arguments and instead emphasized the Commission's power under 29 U.S.C. § 659(c) to "affirm, modify, or

[13] 29 U.S.C. § 658(a) states that the "Secretary may prescribe procedures for the issuance of a notice in lieu of a citation with respect to de minimus violations."

vacate the Secretary's citation, or to direct other appropriate relief." *Reich,* 998 at 139 (noting that "reducing the violation to de minimus status clearly falls within that grant of power" and that the "Secretary . . . is attempting to enlarge his power at the expense of the 'neutral arbiter'"). The Ninth Circuit also reached its conclusion by emphasizing the OSH Act's requirement that the Commission act as a check on the Secretary's charging decisions by affirming, modifying or vacating her citations "or directing other appropriate relief, as it deems appropriate after conducting fact-finding." *Symms Fruit Ranch, Inc.*, 242 F.3d at 894. That court described as "unreasonable" the Secretary's assertion "that once she issues a citation . . . and establishes . . . a violation, the Commission has no authority to hold that a violation was so negligible or harmless that remediation is unnecessary." *Id. at* 898.

By the rationale accepted in the First, Third, and Ninth Circuits, the Fifth Circuit's conclusion in this case also would be "unreasonable." Accordingly, to ensure consistency and the existence of checks and balances as Congress intended, this Court's guidance is needed to ease the increasing tension between the Commission's adjudicative authority and the Secretary's ever-expanding characterization of her "prosecutorial discretion."

B. The Fifth Circuit Decision Relies on a Mistaken Characterization of This Court's *Cuyahoga* Decision.

The Fifth Circuit relied upon *Cuyahoga Valley Ry. Co. v. United Transp. Union*, 474 U.S. 3, 7-8 (1985), for the proposition that "the Secretary may group willful violations at the charging stage, whereas the Commission may not group per-instance willful violations at the penalty

stage." App. 6. This is a far-reaching interpretation of *Cuyahoga,* which held only that "the Secretary has the authority to determine if a citation should be issued to an employer for unsafe working conditions," and that "the Secretary's decision to *withdraw* a citation against an employer under the Act is not reviewable from the Commission." *Id.* (emphasis added).

The Ninth Circuit rejected this interpretation of *Cuyahoga* in *Symms Fruit Ranch.* In that instance, the Secretary relied upon *Cuyahoga* for the premise that her prosecutorial discretion gave her the exclusive authority to classify a violation as de minimus. 242 F.3d at 899. However, the *Symms Fruit Ranch* court held that *Cuyahoga* was easily "distinguishable" and only "consistent with the unremarkable general proposition that if a plaintiff no longer wishes to prosecute a case, the court cannot require him to continue." *Id.*

The Secretary's ability to withdraw citations, or even to issue citations on a per-instance basis, is not disputed here. Rather, it is the Commission's authority to act as an adjudicative check and modify her citations if the facts so warrant that is now before the Court. *See Reich,* 998 F.3d at 139 (noting that the reduction of offense level is "analogous to the power of a court to reduce a criminal offense to a lesser level than the one charged in an indictment" and "has not been considered to be a usurpation of prosecutorial discretion, but rather a necessary prerogative of the court"). Given that 29 U.S.C. § 259(c) expressly permits such modification, the Fifth Circuit's expansive interpretation of *Cuyahoga* is unsupportable.

The Secretary's and Fifth Circuit's misplaced reliance on *Cuyahoga* underscores their misunderstanding of the

statutorily mandated balance of power between the Secretary and the Commission. Congress created the Commission as a safeguard against the Secretary's unreviewed, unproven charging decisions and in order to ensure that penalty assessment authority rested with an adjudicative body that has the ultimate ability to affirm or modify the Secretary's proposals after consideration of all the evidence. If allowed to stand, the Fifth Circuit's decision would flout that principle, create a rift among the circuits and greatly expand the unchecked authority of the Secretary at the expense of employers throughout the Fifth Circuit.

CONCLUSION

Therefore, Petitioners respectfully request and pray that the Court grant this Petition for Writ of Certiorari, reverse or vacate the Judgment of the United States Court of Appeals, and remand this case for further proceedings.

Respectfully submitted,

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480 F.3d 320

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

Elaine CHAO, Secretary, Department of Labor,
Petitioner,
v.
OCCUPATIONAL SAFETY AND HEALTH
REVIEW COMMISSION; Saw Pipes USA, Inc.,
Respondents.

Elaine Chao, Secretary, Department of Labor,
Petitioner,
v.
Jindal United Steel Corp.; Occupational
Safety and Health Review Commission,
Respondents.

Nos. 05-61087, 05-61089.

Feb. 21, 2007.

Petition for Review from the Occupational Safety and Health Review Commission.

Before GARZA, DeMOSS and OWEN, Circuit Judges.

EMILIO M. GARZA, Circuit Judge:

This case asks us to address the scope of the Occupational Safety and Health Review Commission's ("the Commission") authority to group, for penalty assessment, violations which were charged and proven on a per-instance basis. The statutory framework grants the Commission the authority to assess penalties, but the framework also requires that the Commission assess a penalty between $5,000 and $70,000 for each willful violation. *See* 29 U.S.C. § 666(a) and (j). In this case, the administrative law judge ("ALJ") found numerous willful violations, but grouped the willful violations, so as to treat each company as if it had only

committed a single willful violation. Jindal and Saw Pipes argue that the grouping of these violations is consistent with the Commission's authority to assess penalties, while the Secretary of Labor ("the Secretary") argues that grouping these offenses violates the statutorily required minimum penalty for each offense. We agree with the Secretary and remand for reassessment of the penalty.

I

The facts of this case are not contested. Jindal and Saw Pipes ("the respondents") are related companies sharing space at the same facility. The ALJ found that, over the course of 1998 to 2000, Jindal committed 82 willful violations and Saw Pipes committed 59 willful violations of the recordkeeping regulation, 29 C.F.R. § 1904.2(a),[1] by intentionally and knowingly failing to record certain work-related accidents or illnesses. In this court, the respondents did not file a cross-appeal challenging that ALJ's determination that each of these violations occurred or that each of these violations was willful.

In the Secretary's enforcement capacity, she can, through the Occupational Safety and Health Administration, investigate and cite violations of the Occupational Safety and Health Act ("OSH Act") and propose penalties for those violations. The Commission and the ALJ determine whether the facts support the citations and assess a

[1] At the time the citations were issued, 29 C.F.R. § 1904.2(a) read, "Each employer shall, . . . (1) maintain in each establishment a log and summary of all recordable occupational injuries and illness for that establishment; and (2) enter each recordable injury and illness on the log and summary as early as practicable but no later than 6 working days after receiving information that a recordable injury or illness has occurred."

penalty. In this case, the Secretary chose not to group the respondents' violations of the recordkeeping regulation and did not propose a single penalty for grouped offenses. Rather, she cited each individual recordkeeping violation and sought a penalty of $9,000 per willful violation for Jindal and $8,000 per willful violation for Saw Pipes. The respondents contested the proposed penalty; the ALJ responded by treating the respondents as if they had each only committed one willful violation and assessed a penalty of $70,000 for each. The Secretary appealed the ALJ's penalty assessment to the Commission. The two commissioners who heard the case on appeal did not reach an agreement on the propriety of the ALJ's grouping decision. Because all official action of the Commission requires an affirmative vote of two members, 29 U.S.C. § 661(f), the commissioners vacated the direction for review, therefore allowing this court to directly review the decision of the ALJ. 29 U.S.C. §§ 660(b) and 661(j); *W.G. Yates & Sons Constr. Co. v. OSHRC,* 459 F.3d 604, 606 (5th Cir.2006) ("Because the Review Commission declined discretionary review of [respondent]'s citation, we treat the decision of the ALJ as a final order of the Commission.").

II

The ALJ's findings of fact and reasonable inferences drawn from those facts are reviewed for "substantial evidence." *MICA Corp. v. OSHRC,* 295 F.3d 447, 449 (5th Cir.2002). The ALJ's "legal conclusions can only be set aside if they are arbitrary, capricious, an abuse of discretion, or not in accordance with law." 5 U.S.C. § 706(2)(A);

see also Chao v. OSHRC, 401 F.3d 355, 367 (5th Cir.2005); *Corbesco, Inc. v. Dole,* 926 F.2d 422, 425 (5th Cir.1991).[2]

As an initial matter we note that not all violations of the OSH Act are susceptible to per-instance citations, but the Commission has clearly held that recordkeeping violations can be cited on a per-instance basis, and that issue is not now before us. *Caterpillar, Inc.,* 15 O.S.H. Cas. (BNA) 2153, 1993 WL 44416, *22 ("[S]ection 1904.2(a)'s requirement to 'enter each recordable injury' can reasonably be read to involve as many violations as there were failures to record, particularly when the injuries took place over a period of time and involved different employees and different types of injury and treatment."); *see also Kaspar Wire Works, Inc. v. Sec'y of Labor,* 268 F.3d 1123, 1132 (D.C.Cir.2001) (discussing the propriety of per-instance citations for recordkeeping violations). Although multiple recordkeeping violations may stem from a single company policy, each failure to record may represent a separate and distinct violation from each other failure to record. In this case, the ALJ affirmed that Jindal and Saw Pipes respectively committed 82 and 59 willful recordkeeping violations.

The statute covering willful violations, 29 U.S.C. § 666(a), states that employers who commit willful violations of the Act "may be assessed a civil penalty of not

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[2] In *Chao v. OSHRC,* 401 F.3d 355, 376 (5th Cir.2005) we stated, "This Court reviews the Commission's determination of the amount of an OSH Act penalty for abuse of discretion." We note in that case, the abuse of discretion standard was applied to the Commission's consideration of the statutory penalty factors in 29 U.S.C. § 666(j). The ALJ's consideration of the statutory penalty factors is not an issue in this case.

more than $70,000 for each violation, *but not less than $5,000 for each willful violation.*" *Id.* (emphasis added). This language would seem to indicate that where the Secretary has charged and the Commission has found multiple willful violations, the Commission must assess a penalty between $5,000 and $70,000 for each violation. The respondents contend that this reading of the statute is incorrect and that the Commission's authority to assess penalties is not so inflexible.

To support this position, the respondents argue that the Commission's authority to assess penalties entails an authority to group, where appropriate, multiple willful violations so as to treat the multiple willful violations as one willful violation. The appropriateness standard upon which the respondents rely stems from 29 U.S.C. § 666(j), which states,

> The Commission shall have authority to assess all civil penalties provided in this section, giving due consideration to the appropriateness of the penalty with respect to the size of the business of the employer being charged, the gravity of the violation, the good faith of the employer, and the history of previous violations.

Id. In this case, after considering size, gravity, good faith, and history, the ALJ determined that an appropriate penalty for each respondent was a single penalty of $70,000 for all willful violations and stated, "To effectuate the penalty, all willful items are grouped under one willful violation and assessed the maximum penalty of $70,000." *Jindal United Steel Corp.,* 2001 O.S.H.D. (CCH) P32528, 2002 WL 221131, *30; *see also Saw Pipes,* 2005 WL 2697262, *18 ("Taking these factors into account, I find that a more appropriate penalty would be reached by

grouping all recordkeeping instances into a single violation with a single penalty.").

By arguing that the ALJ's appropriateness determination may be used to modify the number of violations, the respondents misunderstand the relationship between § 666(a) and § 666(j) and the function of a mandatory minimum. The ALJ should not apply the appropriateness factors of § 666(j) first, and then manipulate the number of violations so that the penalty range fits his appropriateness determination. Rather, the ALJ should determine the penalty range based on the number of violations separately charged and proven and then assess an appropriate penalty from within that range.[3] This is consistent with the statutory structure. The Commission's authority to assess penalties is limited to the penalties "provided in this section." 29 U.S.C. § 666(j). For willful violations, the penalties provided in § 666 require that *each* willful violation be assessed a penalty within the range of $5,000

[3] Although § 666(a) is a limitation on the Commission's authority to assess penalties, it should not be read as a restriction on the Secretary's prosecutorial discretion to cite only a single willful violation where the facts alleged would support numerous willful violations. *See Heckler v. Chaney*, 470 U.S. 821, 831, 105 S.Ct. 1649, 84 L.Ed.2d 714 (1985) ("This Court has recognized on several occasions over many years that an agency's decision not to prosecute or enforce, whether through civil or criminal process, is a decision generally committed to an agency's absolute discretion."); *see also Cuyahoga V.R. Co. v. United Transp. Union*, 474 U.S. 3, 7, 106 S.Ct. 286, 88 L.Ed.2d 2 (1985) ("The Commission's function is to act as a neutral arbiter and determine whether the Secretary's citations should be enforced over employee or union objections. Its authority plainly does not extend to overturning the Secretary's decision not to issue or to withdraw a citation."). In other words, the Secretary may group willful violations at the charging stage, whereas the Commission may not group per-instance willful violations at the penalty stage.

to $70,000. 29 U.S.C. § 666(a). Congress has set these as the boundaries for the Commission's application of the § 666(j) appropriateness factors; to the extent that the Commission disagrees with Congress's judgment as to what penalty is appropriate for any given willful violation, the Commission must yield to Congress.

This reading of the statutory language is underscored by the history of the statute. When the OSH Act was implemented initially in 1970, there was no mandatory minimum for willful violations and the maximum penalty was $10,000. OSH Act § 17(a), 84 Stat. 1606, 1607 (1970). The Commission was free to apply the appropriateness standard of § 666(j) without concern for violating any sort of statutory floor to the penalty assessment. But Congress added the $5,000 mandatory minimum in 1990, at the same time Congress increased the maximum penalty from $10,000 to $70,000. Pub.L. 101-508 § 3101(1), 104 Stat. 1388-29 (1990). The clear intent of Congress was to constrain the Commission's discretion in assessing minimum penalties for willful violations and to increase the amount of the penalties. Allowing the Commission to treat multiple willful violations as a single willful violation runs contrary to this intent.

Further, the respondents discuss at length that the Commission is not bound by the Secretary's penalty proposals. Without question, this is correct. *Chao v. OSHRC,* 401 F.3d 355, 376 (5th Cir.2005) ("The Commission has the exclusive authority to assess penalties once a proposed penalty is contested."). This fact, though, is not relevant to the issue before us. The Secretary's charging decision whether to cite the employer for a single violation or for per-instance violations is not itself a penalty proposal. The penalty proposal is the amount the Secretary is

seeking, not the number of violations. Therefore, the Commission's authority to set a penalty different from that proposed by the Secretary does not entail the authority to change the number of violations charged and disregard the number of violations proven. *See Caterpillar Inc. v. Herman,* 131 F.3d 666, 668 (7th Cir.1997) (concluding that the Commission must assess a penalty for all violations cited and proven).

Lastly, the respondents argue that requiring the Commission to impose a mandatory minimum penalty for each per-instance willful violation would contradict a long history supporting the Commission's authority to group violations. This reading of the Commission's historical practice is contradicted by both OSHRC commissioners who addressed the merits of the case without ruling on it. Commissioner Railton stated, "Where the cited provision is found susceptible to per-instance citation, the Commission has generally assessed individual penalties," and pointed out that "the law in this area is 'still developing.'" *Jindal Steel Corp.,* 21 O.S.H. Cas. (BNA) 1298 (2005), 2005 WL 2697263, *9; *see also Andrew Catapano Enter., Inc.,* 17 O.S.H. Cas. (BNA) 1776 (1996), 1996 WL 559899, *12 (suggesting that the Commission has generally assessed multiple penalties for multiple violations). Commissioner Rogers stated that the circumstance of the instant case is novel.[4] *Id.* at ("[T]his case presents, for the

[4] The only case respondents cited which is directly on point – where the Secretary properly issued citations on a per-instance basis, the ALJ found multiple willful violations, and the ALJ imposed a single grouped penalty below the mandatory minimum – is *John B. Coffman,* 19 O.S.H. Cas. (BNA) 1043 (2000), 2000 WL 635767. In that case, the Secretary did not appeal the penalty assessment, so the issue was never reached by the Commission.

first time, the question whether the Commission may now assess an aggregate penalty for multiple affirmed violations that amounts to less than $5,000 for 'each [willful] violation.'") (second modification in original).[5]

III

In sum, we find that 29 U.S.C. § 666(a) establishes a mandatory penalty range of $5,000 to $70,000 for each willful violation charged and proven. The Commission's statutory authority to assess penalties under 29 U.S.C. § 666(j) requires that the Commission assess an appropriate penalty within the range established by § 666(a), and does not authorize the Commission to go above or below that penalty range. As a result, the Commission cannot group separately charged and proven willful offenses for the purposes of assessing a penalty. Therefore, we VACATE the ALJ's penalty assessment and REMAND for proceedings not inconsistent with this opinion.

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[5] The cases the respondents rely on are not relevant for various reasons, namely that they applied the pre-mandatory minimum version of the statute, *see, e.g., Safeway Stores, Inc.*, 2 O.S.H. Cas. (BNA) 1439 (1974), 1974 WL 4590; *H.H. Hall Constr. Co.*, 10 O.S.H. Cas. (BNA) 1042 (1981), 1981 WL 18913; do not involve the grouping of multiple willful violations, *see, e.g., Hackensack Steel Corp.*, 20 O.S.H. Cas. (BNA) 1387 (2003), 2003 WL 22232017; *MICA Corp.*, 19 O.S.H. Cas. (BNA) 1618, 2001 WL 826750; or involve the Secretary grouping the violations at the charging stage, *see, e.g., Cherry Hill Stairs*, 17 O.S.H. Cas. (BNA) 1416 (1995), 1995 WL 813190.

21 O.S.H. Cas. (BNA) 1306

OCCUPATIONAL SAFETY HEALTH
REVIEW COMMISSION
SECRETARY OF LABOR, Complainant
v.
SAW PIPES USA, INC., and its successors, Respondent

OSHRC Docket No. 01-0422
FINAL ORDER DATE: September 28, 2005

DECISION

Before: RAILTON, Chairman; and ROGERS, Commissioner.

The Occupational Safety and Health Administration ("OSHA") commenced an inspection of Saw Pipes USA, Inc.'s ("Saw Pipes") facility in Baytown, Texas on July 27, 2000, and subsequently cited Saw Pipes for numerous alleged willful and serious violations of various standards under the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-687 ("OSH Act" or "Act"). The parties resolved, by settlement agreement and joint stipulation, all of the citations except certain items pertaining to Saw Pipes' alleged failure to properly record occupational illnesses and injuries in violation of 29 C.F.R. § 1904.2(a).[1]

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[1] At the time these violations occurred, 29 C.F.R. § 1904.2(a) provided that:

> Each employer shall, . . . (1) maintain in each establishment a log and summary of all recordable occupational injuries and illnesses for that establishment; and (2) enter each recordable injury and illness on the log and summary as early as practicable but no later than 6 working days after receiving information that a recordable injury or illness has occurred. For this purpose form OSHA No. 200 or an equivalent which is as readable and comprehensible to a

(Continued on following page)

With the exception of one grouped citation, the Secretary cited the recordkeeping violations as willful on a per-instance basis, and proposed a penalty of $8,000 for each of the violations.[2] Administrative Law Judge James H. Barkley affirmed fifty-nine separate recordkeeping violations as willful, but grouped them for penalty purposes and assessed a single penalty of $70,000.

On review, Saw Pipes contests only the characterization of the violations as willful, and argues for lower penalties. The Secretary challenges the judge's penalty grouping. The two Commission members would affirm the judge's characterization of the violations as willful, but are divided as to the appropriate penalty assessment.

Official action of the Commission requires the affirmative vote of two members on all dispositive issues. OSH Act, § 12(f), 29 U.S.C. § 661(e). In view of the absence of such agreement here and to resolve this impasse, the Commission members agree to vacate the direction for review, thereby allowing the judge's Decision and Order to become the final appealable order of the Commission with the precedential value of an unreviewed judge's decision.[3]

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person not familiar with it shall be used. The log and summary shall be completed in the detail provided in the form and instructions on form OSHA No. 200.

[2] In Citation 1, Item 67, the Secretary grouped multiple instances of incorrectly recorded items into a single violation for which she proposed a single penalty. The judge affirmed some of the individual instances and vacated others.

[3] Notwithstanding our action vacating the direction for review in this case, this was an appropriate case for review. The order vacating the direction for review is entered in order to allow the parties to bring finality to this case. The decisions of some United States courts of appeals have rejected alternative forms of dispositions of our cases when only two members are available to decide cases. *See, e.g., Cox*

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See e.g., The Timken Co., 20 BNA OSHC 2034 (No. 97-1457, 2004), and cases there cited. *See also* sections 10(c), 11(a) and (b), and 12(j) of the Act, 29 U.S.C. §§ 659(c), 660(a) and (b), and 661(i). Accordingly, the direction for review is hereby vacated. The separate views of the two Commission members follow.

SO ORDERED.

W. Scott Railton
Chairman

Thomasina V. Rogers
Commissioner

Dated: September 28, 2005

I. The characterization of Saw Pipes' recordkeeping violations

Saw Pipes manufactures steel pipe at a former USX steel facility that it shares with Jindal United Steel Corp. ("Jindal"). The two related companies share some common ownership and some managerial personnel.[4] On review, Saw Pipes does not dispute the judge's finding that it failed to properly record 63.7% of the recordable injuries and illnesses on its OSHA 200 logs for the cited period during 1998, 1999, and 2000. Having thoroughly reviewed the record in this case, Chairman Railton and Commissioner Rogers agree that the record supports the judge's

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Brothers v. Secretary of Labor, 574 F.2d 465 (9th Cir. 1978); *Shaw Construction, Inc. v. OSHRC*, 534 F.2d 1183 (5th Cir. 1976).

[4] We also issue today a decision vacating the direction for review in *Jindal United Steel Corp.* ("*Jindal*"), Docket No. 00-2231, which involves the identical questions presented here.

conclusion that Saw Pipes' recordkeeping errors were willful.

As the Commission stated in *Kaspar Wire Works, Inc.*, "[t]he hallmark of a willful violation is the employer's state of mind at the time of the violation – an 'intentional, knowing, or voluntary disregard for the requirements of the Act or . . . plain indifference to employee safety."' 18 BNA OSHC 2178, 2181 (No. 90-2775, 2000) (citation omitted), *aff'd*, 268 F.3d 1123 (D.C. Cir. 2001). "[T]he Secretary must show that the employer acted voluntarily, with either intentional disregard of or plain indifference to OSHA requirements." *Georgia Elec. Co. v. Marshall*, 595 F.2d 309, 317-319 (5th Cir. 1979). *Accord AJP Constr. Inc. v. Secretary*, 357 F.3d 70, 74 (D.C. Cir. 2004).

Here, during the period covered by the citations, Robert Murphey, Saw Pipes' safety manager and certified industrial safety technician, maintained Saw Pipes' OSHA 200 logs. Through his education and previous work experience, Murphey was familiar with OSHA standards and recordkeeping regulations, as well as the contents of the U.S. Department of Labor, Bureau of Labor Statistics publication entitled *Recordkeeping Guidelines for Occupational Injuries and Illnesses*. The evidence shows that Murphey worked ten-hour days, seven days a week, and that he responded to and investigated all accidents and injuries that occurred during his shift. At other times, Saw Pipes' security personnel investigated such incidents, and notified Murphey of the events thereafter. Murphey also gathered illness and injury information from the "incident reports" generated by Saw Pipes' supervisory personnel, treating physician accident reports and return-to-work restrictions, and copies of the on-site clinic log.

Murphey claims that he made every effort to follow up on accidents and incidents in order to keep the OSHA 200 log up to date, and that he never intentionally failed to record an injury that he knew was recordable. He blames his failure to properly record on inadequate information from supervisors and clinic staff. Although the record shows that some incident reports were delayed, we agree with the judge that Murphey's first-hand knowledge of most incidents, combined with his access to redundant sources of employee illness and injury information, belies his claim that inadequate information precluded him from properly maintaining Saw Pipes' OSHA 200 logs. *See Kaspar Wire Works, Inc. v. Secretary*, 268 F.3d 1123, 1128-29 (D.C. Cir. 2001) (finding that factual evidence belied Kaspar's claim that its actions were merely negligent or careless).

Murphey reported directly to Gary Jones, Saw Pipes' human resources and labor relations director. Jones was the architect of Jindal's recordkeeping program, through which he knowingly enforced erroneous guidelines that resulted in a large number of recording errors.[5] Jones had instructed Jindal's recordkeeper to exclude from the OSHA 200 those injuries not reported to workers' compensation, and the injuries and illnesses of temporary laborers who worked at the plant.

Although Murphey testified that Jones never told him what to record on Saw Pipes' OSHA 200 logs, Jones acknowledged having "ultimate responsibility" for the OSHA

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[5] The judge granted the Secretary's unopposed motion to make portions of the *Jindal* transcript that included this evidence part of the record here.

200s. Jones also received and reviewed, along with Murphey, the supervisors' illness and injury reports, and medical bills for employees referred to the off-site clinic. As the judge noted, Jones and his staff "inherited a pre-existing reporting system" to which procedures were added that "should have increased reporting accuracy." Nonetheless, the undisputed recordkeeping data bear out the judge's observation that "[d]espite the increase in the number and expertise of safety personnel, . . . the timeliness and accuracy in recording injuries plummeted after Jones took over the management of Saw's safety department" and "did not improve when Robert Murphey took over responsibility for the logs in May 1998."

There is also evidence that Jones directly intervened to control the medical information upon which recordability would depend. The medical supervisor of Saw Pipes' on-site clinic provided unrebutted testimony that Jones attempted to persuade him to refrain from ordering restricted work for injured employees. Speaking with the doctor several times each week, Jones criticized work restriction orders, and asked in many particular instances that patient records contain "no restrictions" notations despite Jones' knowledge that the patient could not perform job-related duties.

As a management official who actively oversaw and participated in Saw Pipes' OSHA 200 compliance, Jones is accountable for the vast errors contained in the company logs for the cited years. The evidence shows that he and Murphey fully understood the recordkeeping requirements, had actual knowledge of the employee illness and injury incidents that should have been recorded, and knowingly failed to comply with the applicable regulations. *See AJP Constr. Inc. v. Secretary*, 357 F.3d at 74

(affirming willful violation where employer knew of standards' requirements and had notice of deficiencies in compliance). Moreover, as the judge noted, Saw Pipes "crossed the line" when it "intrud[ed] into the doctor/patient relationship" by attempting to influence doctors' orders for work restrictions. Accordingly, we agree with the judge that the cited recordkeeping violations were willful.[6]

II. Penalties

The judge affirmed fifty-nine separate violations for Saw Pipes' fifty-nine recordkeeping errors, which the Secretary cited on a per-instance basis and which the parties do not contest on review. With respect to the penalties, however, the judge rejected the Secretary's proposal of $8,000 for each willful violation and, instead, assessed a single grouped penalty of $70,000.

Chairman Railton's Views

For the reasons more fully articulated in *Jindal*, Chairman Railton believes that the judge properly assessed a single $70,000 penalty for Saw Pipes' willful recordkeeping violations. In particular, Chairman Railton notes that in assessing a single combined penalty, the judge properly took into account the Secretary's own

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[6] The judge also properly rejected Saw Pipes' "good faith belief" defense to willfulness with respect to the temporary laborers. Saw Pipes directly supervised the temporary workers which, as Jones knew, made it responsible for recording their injuries and illnesses. *See Froedtert Memorial Lutheran Hospital, Inc.*, 20 BNA OSHC 1500, 1510 (No. 97-1839, 2004) (citations omitted).

theory of the case – that Saw Pipes engaged in a single pattern and practice of willful non-reporting. As the judge stated "[t]he evidentiary path chosen by Complainant was considerably less onerous than showing willfulness in each and every instance."

Nor did the Secretary establish that these violations were willful *and* egregious. The record is devoid of evidence properly showing the requisite high gravity or significant bad faith to merit per-instance penalties under the egregious/willful penalty policy. The judge analyzed the evidence on this issue.[7] Chairman Railton would also find that the gravity of Saw Pipes' recordkeeping violations was low. As the judge noted, the unreported injuries were relatively minor, and a review of Saw Pipes' safety violations reveals no intent to cover up serious safety hazards.

Although "intentional disregard" of safety and health responsibilities is another of the willful/egregious factors that may support enhanced penalties, as Chairman Railton explained in *Jindal*, this factor "is thoroughly redundant" here as it comprises the sole basis of the willful characterization. In the absence of any other indicia of bad faith, application of the violation-by-violation penalty policy is not merited. Accordingly, Chairman Railton would affirm the judge's penalty assessment of a single grouped penalty of $70,000 for Saw Pipes' fifty-nine recordkeeping violations.

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[7] Chairman Railton notes that his colleague sidesteps the fact that it is the policy of the Secretary to distinguish between willful violations committed in a non-egregious manner from those which she characterizes as egregious/willful violations.

Commissioner Rogers' Views

For the reasons more fully articulated in *Jindal*, Commissioner Rogers believes that the judge exceeded his statutory authority by assessing a single $70,000 penalty for fifty-nine separate willful violations. In her view, the amended Act plainly requires that the Commission assess a penalty of at least $5,000 for each of the fifty-nine affirmed willful violations.

In particular, Commissioner Rogers takes issue with her colleague's assertion that because the evidence here shows a pattern and practice of willful non-reporting, individual willful penalties are not warranted. The OSH Act does not distinguish among theories of willfulness as a predicate for imposing the minimum willful penalty. It merely states that a penalty "not less than $5,000" must be assessed "for each willful violation." Having affirmed each of Saw Pipes' fifty-nine recordkeeping violations as willful, the Commission must apply the statutory penalty scheme as written.

Commissioner Rogers also emphasizes that Saw Pipes' managers personally completed the OSHA 200 forms, and the evidence shows that their willful noncompliance with the cited regulations was, indeed, egregious. Human resources director Gary Jones, in conjunction with safety manager Robert Murphey, were directly responsible for the sorry state of Saw Pipes' illness and injury reporting. As we noted above, they "fully understood the recordkeeping requirements, had actual knowledge of the employee illness and injury incidents that should have been recorded, and knowingly failed to comply with the applicable regulations." The evidence in this case shows such a disregard for compliance with the recordkeeping regulations

that, even absent proof of employer knowledge of each recordkeeping error, "it could be inferred that if [Saw Pipes] had known of the [recordable events], it would not have cared that it was in violation of the Act." *A.E. Staley Mfg. Co.*, 19 BNA OSHC 1199, 1211, 1222 (No. 91-0637, 2000) (consolidated) (finding that evidence established "pattern and course of conduct" demonstrating plain indifference), *aff'd*, 295 F.3d 1341, 1350-53 (D.C. Cir. 2002) (noting that knowledge regarding acts of omission can be inferred from evidence of plain indifference). In these circumstances, as in *Jindal*, Commissioner Rogers would find that Saw Pipes demonstrated "a level of bad faith that clearly justifies the Secretary's lawful exercise of her discretion to cite these violations separately and the penalties that statutorily flow from it." Accordingly, a $5,000 penalty for each of the fifty-nine willful violations would be reasonable and appropriate

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21 O.S.H. Cas. (BNA) 1298

OCCUPATIONAL SAFETY HEALTH
REVIEW COMMISSION
SECRETARY OF LABOR, Complainant
v.
JINDAL UNITED STEEL CORP., and its successors,
Respondent

OSHRC Docket No. 00-2231
FINAL ORDER DATE: September 28, 2005

DECISION

Before: RAILTON, Chairman; and ROGERS, Commissioner.

The Occupational Safety and Health Administration ("OSHA") inspected Jindal United Steel Corporation's ("Jindal") manufacturing facility in Baytown, Texas from May 10, 2000 until October 19, 2000. The Secretary cited Jindal for numerous alleged willful and serious violations of various standards under the Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-687 ("OSH Act" or "Act"). The parties resolved, by settlement agreement and joint stipulation, all of the citations except certain items pertaining to Jindal's alleged failure to properly record occupational illnesses and injuries in violation of 29 C.F.R. § 1904.2(a).[1] The Secretary cited the recordkeeping

[1] At the time these violations occurred, 29 C.F.R. § 1904.2(a) provided that:

> Each employer shall, . . . (1) maintain in each establishment a log and summary of all recordable occupational injuries and illnesses for that establishment; and (2) enter each recordable injury and illness on the log and summary as early as practicable but no later than 6 working days after

(Continued on following page)

violations as willful on a per-instance basis, and proposed a penalty of $9,000 for each of the violations. Administrative Law Judge James H. Barkley affirmed 110 separate recordkeeping violations, but grouped them for penalty purposes, assessing a single penalty of $70,000 for the eighty-two items he affirmed as willful, and $7,000 for the twenty-eight items he affirmed as other-than-serious.

On review, Jindal contests only the characterization of the eighty-two citations that the judge affirmed as willful, and argues for lower penalties. The Secretary argues that all of the violations were willful and challenges the judge's penalty grouping. The two Commission members would affirm the judge's characterization of the eighty-two willful violations, but are divided as to the characterization of the remaining twenty-eight violations and the appropriate penalty assessment for the willful violations.

Official action of the Commission requires the affirmative vote of two members on all dispositive issues. OSH Act, § 12(f), 29 U.S.C. § 661(e). In view of the absence of such agreement here and to resolve this impasse, the Commission members agree to vacate the direction for review, thereby allowing the judge's Decision and Order to become the final appealable order of the Commission with the precedential value of an unreviewed judge's decision.[2]

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receiving information that a recordable injury or illness has occurred. For this purpose form OSHA No. 200 or an equivalent which is as readable and comprehensible to a person not familiar with it shall be used. The log and summary shall be completed in the detail provided in the form and instructions on form OSHA No. 200.

[2] Notwithstanding our action vacating the direction for review in this case, this was an appropriate case for review. The order vacating the direction for review is entered in order to allow the parties to bring

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See e.g., The Timken Co., 20 BNA OSHC 2034 (No. 97-1457, 2004), and cases there cited. *See also* sections 10(c), 11(a) and (b), and 12(j) of the Act, 29 U.S.C. §§ 659(c), 660(a) and (b), and 661(i). Accordingly, the direction for review is hereby vacated. The separate views of the two Commission members follow.

SO ORDERED.

W. Scott Railton
Chairman

Thomasina V. Rogers
Commissioner

Dated: September 28, 2005

I. The characterization of Jindal's recordkeeping violations

Jindal commenced operation in 1997 at a former USX steel facility where it operates the plate mill portion of a steel manufacturing business. Jindal shares the business with Saw Pipes USA, Inc., a related company located at the same facility that manufactures steel pipe.[3] The two companies share some common ownership and some managerial personnel. On review, Jindal does not dispute that it failed to properly record 74% of the recordable

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finality to this case. The decisions of some United States courts of appeals have rejected alternative forms of dispositions of our cases when only two members are available to decide cases. *See, e.g., Cox Brothers v. Secretary of Labor*, 574 F.2d 465 (9th Cir. 1978); *Shaw Construction, Inc. v. OSHRC*, 534 F.2d 1183 (5th Cir. 1976).

[3] We also issue today our decision vacating the direction for review in *Saw Pipes*, Docket No. 01-0422, which involves questions identical to those presented here.

illnesses and injuries on its OSHA 200 log in 1998, 84% in 1999, and 53% for the first half of 2000. Having thoroughly reviewed the record in this case, Chairman Railton and Commissioner Rogers agree that the judge's factual findings are fully supported by the testimony and evidence. In addition, they would agree with the judge, for the reasons he articulated, that the recordkeeping errors attributable to employees Craig Wetherington and Lisa White were willful.

As the Commission stated in *Kaspar Wire Works, Inc.*, "[t]he hallmark of a willful violation is the employer's state of mind at the time of the violation – an 'intentional, knowing, or voluntary disregard for the requirements of the Act or . . . plain indifference to employee safety."' 18 BNA OSHC 2178, 2181 (No. 90-2775, 2000) (citation omitted), *aff'd*, 268 F.3d 1123 (D.C. Cir. 2001). "[T]he Secretary must show that the employer acted voluntarily, with either intentional disregard of or plain indifference to OSHA requirements." *Georgia Elec. Co. v. Marshall*, 595 F.2d 309, 317-319 (5th Cir. 1979). *Accord AJP Constr. Inc. v. Secretary*, 357 F.3d 70, 74 (D.C. Cir. 2004). Here, the evidence shows that Jindal managerial personnel intentionally implemented recordkeeping practices that they knew were incorrect. Gary Jones, human resources and labor relations director for Saw Pipes who hired and supervised Jindal recordkeeper Craig Wetherington, was the architect of Jindal's recordkeeping program. Despite Wetherington's repeated protests, Jones instructed Wetherington to record on the OSHA 200 only those injuries reported to workers' compensation, which excluded injuries for which Jindal absorbed the cost of an employee's lost work time and medical treatment. He also instructed that Jindal would not record on its OSHA log

the injuries and illnesses of the temporary laborers who worked at the plant. Wetherington advised Jones that these recordkeeping practices were not consistent with his prior experience or with OSHA published recordkeeping guidelines, and that following them would leave "the company wide open for problems with OSHA and other people." According to Wetherington, Jones rejected his concerns and told him that if he could not comply with Jones' instructions "there's the door."[4]

Wetherington complained about Jones' recordkeeping practices to Jindal human resources manager Lisa White and plant manager Doug Gates, but to no avail. Gates told Wetherington that Jones "is the one that's running the program. It's his way." Similarly, White stated that Jones "had the final word on that. We have to go by what he says, period." Wetherington testified that when he told Gates that by following Jones' instructions he was failing to comply with OSHA recordkeeping requirements, Gates recommended that he protect himself by writing a memorandum to that effect. White corroborated Wetherington, testifying that Wetherington "had approached both myself

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[4] Although Jindal argues that the absence of a clear correlation between its OSHA log and workers' compensation claims rebuts Wetherington's testimony and belies the existence of a policy to under record, we note that neither motive nor a consistent pattern of misrecording is a prerequisite to willfulness. *Kaspar*, 18 BNA OSHC at 2183-84 (finding recordkeeping errors willful where resulting from "an overall disregard of the regulation's requirements"). Jindal's contention that it had a good faith belief that it need not record temporary laborers' illnesses and injuries is also properly rejected. As the judge noted, it was Jindal's responsibility to supervise the temporary workers which, as Wetherington advised Jones, made Jindal responsible for recording their injuries and illnesses. *See Froedtert Memorial Lutheran Hospital, Inc.*, 20 BNA OSHC 1500, 1510 (No. 97-1839, 2004) (citations omitted).

and Doug Gates with his concerns. His concerns were that he was being directed to do this by his supervisor; however, he knew that this was a violation of the recordkeeping requirements, but he needed his job and he was fearful that if he did not do as instructed, he might lose his job. So it was Doug Gates and my recommendation to go ahead and just note that to the file so that he would have a cover for himself should anything ever arise."

White also echoed Wetherington's concerns, testifying that she was "afraid that subsequently if OSHA were to come in and do a recordkeeping audit or any kind of another audit on us, that we would be exposed to great citations from that." Nonetheless, when White briefly assumed responsibility for completing Jindal's OSHA logs following Wetherington's resignation, she chose to continue the established recordkeeping practices, admitting that she knowingly failed to properly record injuries at that time. In these circumstances, Chairman Railton and Commissioner Rogers fully agree with the judge's conclusion that Jindal intentionally disregarded its recordkeeping responsibilities in willful violation of the Act for the errors attributable to employees Craig Wetherington and Lisa White. *AJP Constr. Inc. v. Secretary*, 357 F.3d at 74 (affirming willful violation where employer knew of standards' requirements and had notice of deficiencies in compliance).

David McIntosh succeeded Craig Wetherington as Jindal safety manager, a position he held from November 8, 1999 until June 26, 2000. Although Jindal never expressly assigned to McIntosh the responsibility for maintaining the OSHA 200 logs, McIntosh voluntarily relieved Lisa White of the task when he became concerned about the approaching February posting deadline. During

McIntosh's tenure, there were twenty-eight recordkeeping errors on Jindal's OSHA 200 log.

For the following reasons, Chairman Railton agrees with the judge that these violations were not willful. McIntosh noticed that Jindal had been erroneously neglecting to report the occupational injuries not submitted for workers' compensation. He testified, however, that he did not follow Jones' "unwritten" policies, nor did he consciously fail to record a reportable injury. While McIntosh did fail to record some of the injuries that occurred in the first half of 2000, there was a marked improvement over the 84% error rate of the previous year. McIntosh attributed his errors to lack of adequate time and information, and the Secretary has provided no basis from which to conclude that they were purposeful. Based on this evidence, Chairman Railton would find that McIntosh's decision to reject the prior recordkeeping policies and transform Jindal's program showed that his errors were merely negligent. *See American Wrecking Corp. v. Secretary*, 351 F.3d 1254, 1264 (D.C. Cir. 2003) (finding "mere negligence" insufficient to establish willfulness).

Chairman Railton would also reject the Secretary's contention that Jindal management's "failure to inquire whether Wetherington and White's concerns were justified after McIntosh became safety manager . . . demonstrated plain indifference." In his view, although insufficient to bring Jindal fully into compliance, McIntosh's efforts transformed Jindal's recordkeeping practices, negating Jones' abject disregard for OSHA's recordkeeping requirements that Gates and White never endorsed. *Compare Caterpillar, Inc.*, 17 BNA OSHC 1731, 1732 (No. 93-373, 1996), *aff'd*, 122 F.3d 437, 440-41 (7th Cir. 1997) (affirming

willful violation despite change in personnel where violation recurred in otherwise unchanged circumstances). Accordingly, Chairman Railton would affirm the judge's characterization of these twenty-eight recordkeeping violations as other-than-serious.

On the other hand, Commissioner Rogers would affirm the additional twenty-eight recordkeeping violations as willful. Jindal explicitly hired David McIntosh to replace Craig Wetherington as safety manager. McIntosh took up residence in Wetherington's former office and determined his job duties from a review of Wetherington's files. Those files enabled McIntosh to determine "what Craig had done out there," and included accident reports and incomplete OSHA logs. Based on McIntosh's own description of his orientation to the safety manager position at Jindal, management never instructed him in any of the particular requirements of his job. Rather, he was left to divine the job's dimensions based on what his predecessor had done. In these circumstances, McIntosh's denial of responsibility for the OSHA 200's, because "it was never designated as [his]," is contradictory and disingenuous. Moreover, despite McIntosh's claim that he did not follow Jones' unwritten policies and never consciously failed to record a reportable event, McIntosh admitted that there were injuries reported to him that he believed should have been recorded on the OSHA 200s, that he did not record. In view of McIntosh's demonstrated knowledge of recordkeeping requirements, which was sufficient to inform his rejection of Jones' erroneous guidelines, Commissioner Rogers would find that his knowing failure to properly record injuries and illnesses demonstrates conscious disregard for the requirements of the Act.

Commissioner Rogers also disagrees that McIntosh's recordkeeping efforts, designed to "just [] try to keep us covered in case something like this [OSHA inspection] did happen," transformed Jindal's intentional disregard for OSHA recordkeeping into mere negligence. Jindal managers White and Gates permitted Jones to direct Jindal personnel to incorrectly record injuries and illnesses. After McIntosh replaced Wetherington, these same managers did nothing to dismantle the violative recordkeeping practices and policies that prevailed at the plant, nor did they convey to McIntosh precisely what was expected of him. Jindal cannot escape willfulness merely by allowing violative practices of which it was aware to continue, notwithstanding the change of recordkeepers. McIntosh's modest efforts cannot cure Jindal's failure to inform its new safety manager of the "pervasive and continuing nature" of the recordkeeping problem and instruct him in the correct procedures. *See Caterpillar, Inc.*, 17 BNA OSHC at 1732-33 (affirming willful violation where corporation failed to convey to new supervisors "relevant and available information it possessed and which, under the Act, it was responsible for disseminating to those entrusted with the health and safety of its employees"). Accordingly, Commissioner Rogers would affirm all 110 of Jindal's recordkeeping violations as willful.

II. Penalties

The judge affirmed 110 separate violations for Jindal's 110 recordkeeping errors, which the Secretary had cited on a per-instance basis and which the parties do not contest on review. With respect to the penalties, however, the judge rejected the Secretary's proposal of $9,000 for each willful violation and, instead, assessed a single grouped

penalty of $70,000. On review, the Secretary challenges the propriety of the judge's grouping of the willful violations and penalty assessment.

Chairman Railton's Views

The Secretary's citation and penalty policy invoked here is guided by a strategy of compliance inducement through enhanced penalties in cases deemed "egregious/willful." Pursuant to this policy, in cases involving willful violations that meet other specified criteria, the Secretary considers departing from her usual practice of issuing a single citation and single proposed penalty for all alleged violations of the same standard or regulation. Where applied, the Secretary, instead, alleges a separate violation and proposes a separate penalty for each instance of noncompliance. *See* OSHA Instruction CPL 2.80, *Handling of Cases to be Proposed for Violation-by-Violation of Penalties*, 1 BNA OSHR Ref. File 21:9649, 9650 (October 1, 1990).

The Secretary may issue per-instance citations where supported by the language of the standard and where the record establishes the facts sufficient to support each alleged violation. *Chao v. OSHRC (Eric K. Ho)*, 401 F.3d 355 (5th Cir. 2005) (concluding that standard "can be interpreted to allow for citation on a per-employee basis" but noting absence of "employee-specific unique circumstances that could merit citation based on each failure to train an individual employee"). Recordkeeping citations based on separate and distinct recording errors meet those criteria. *E.g., Caterpillar, Inc.*, 15 BNA OSHC 2153, 2170-71 (No. 87-922, 1993).

Where the cited provision is found susceptible to per-instance citation, the Commission has generally also assessed individual penalties. However, as we recently stated in *Eric K. Ho*, "[t]he Commission has taken several steps on the road to assessing individual penalties for per-instance violations[,]" and the law in this area is "still developing." 20 BNA OSHC 1361, 1370 (No. 98-1645, 2003) (consolidated), *aff'd*, 401 F.3d 355 (5th Cir. 2005). In Chairman Railton's view, this case compels the Commission to further define the basis upon which it will determine the "appropriate" penalty assessment in cases cited under the egregious/willful policy. *See* OSH Act, section 17(j).

In this regard, Chairman Railton notes that the Secretary's decision to invoke the egregious policy to propose separate penalties is made before an evidentiary record is compiled. In contrast, the Commission's decision to assess penalties is based upon the evidence adduced in the record as a whole following an evidentiary hearing. *See Hern Iron Works Inc.*, 16 BNA OSHC 1619, 1623 (No. 88-1962, 1994) ("evaluation of . . . penalty factors are issues of fact, the resolution of which is the exclusive province of the Commission"). As the reviewing body within the administrative process, the Commission is best able to determine whether the grounds upon which the penalties were proposed warrant application of the egregious policy at the penalty assessment stage. *See, e.g., Butz et al v. Glover Livestock Comm'n*, 411 U.S. 182 (1973). Accordingly, the Commission must evaluate whether the record evidence is sufficient to satisfy the egregious/willful criteria in determining whether to assess separate penalties for per-instance citations. To date, the Commission has never addressed the obvious gap between the Secretary's policy

and evidentiary insufficiency. Such a reasoned step must be taken to ensure that the evaluation of penalty factors (issues of fact) remain the exclusive province of the Commission.

Under the Secretary's seven-factor test, per-instance penalties may be proposed when the cited violations are willful and egregious, in that they are particularly high gravity or the employer showed significant bad faith. The first factor plus one of the other six are required to support a recommendation for per-instance citations and penalties. The criteria are (1) the elements of a willful characterization; (2) a worker fatality, other catastrophe, or high number of injuries/illnesses; (3) persistently high injury/illness rates; (4) extensive history of prior violations; (5) intentional disregard of safety and health responsibilities; (6) clear bad faith; and (7) such a large number of violations so as to significantly undermine any safety and health program. Of course, these elements are already subsumed within the four statutorily prescribed factors upon which the Commission determines the appropriate penalty under section 17(j).

Chairman Railton would find that the evidence here is insufficient to justify per-instance penalties under the Secretary's test. The judge found that the evidence established that the violations were willful, and that Jindal intentionally disregarded its recordkeeping responsibilities. As the essential basis of the willful characterization, however, the "intentional disregard" factor here is thoroughly redundant and, as such, cannot satisfy the "plus one" requirement of the Secretary's seven-factor test. In the absence of any other indicia of bad faith, and because the violations are of particularly *low* gravity, application of the violation-by-violation penalty policy is not merited.

With respect to the $5,000 minimum willful penalty contained in the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 3101 (1990), Chairman Railton would note that the amendments are not the straitjacket that the Secretary would aver, either for the Commission or for the Secretary herself. Although the Secretary contends that it would be "clear error" to assess a penalty that is less than the "statutory minimum" for each willful violation, Congress intended some flexibility in applying the new penalty structure. As the House Conference Report states, "[t]he conferees d[id] not intend to deprive [OSHA] of the flexibility to settle cases involving willful violations, *where appropriate*, for amounts which are less than the mandatory minimums." H.R. CONF. REP. NO. 101-964, *reprinted in* 1990 U.S.C.C.A.N. 2374, 2393-94 (emphasis added).

The "appropriateness" benchmark identified in the committee report is identical to that which the Commission also must satisfy in exercising its penalty-setting authority pursuant to section 17(j). A total penalty here consisting of $5,000 for each of the eighty-two violations affirmed as willful would amount to $410,000. That is an extraordinary and unprecedented sum for even the largest and most egregious of recordkeeping cases. These circumstances raise the question whether, under the Secretary's approach, there would be any limit to the total penalty for cases involving large numbers of willful recordkeeping errors. The Commission has long cautioned against such a result, emphasizing that:

> The key question for penalty purposes is not how many errors or omissions there [are], but what penalty is appropriate. Thus, although the Secretary may cite separate omissions to record injuries

> as separate violations, he may not exact a total penalty that is inappropriate in light of the four factors listed in section 17(j) of the Act: the gravity of the violations, the employer's good faith, its size, and its history of violations.

Caterpillar, 15 BNA OSHC at 2173.

In his application of the 17(j) factors here, the judge properly considered Jindal's size of 250 employees, the lack of prior OSHA inspections, and "deliberate nature of the violations." Following well-settled precedent, he focused on the gravity of the violations as the most significant consideration in assessing the penalty. *Chao v. OSHRC (Erik K. Ho)*, 401 F.3d at 376, and cases there cited. Gravity generally includes a number of factors, including the number of employees exposed to the hazard, the duration of their exposure, the precautions taken to prevent injury, and the degree of probability that an injury would occur. *E.g. KusTum Builders, Inc.*, 10 BNA OSHC 1128, 1132 (No. 76-2644, 1981). The Commission has long held, however, that recordkeeping violations are of low gravity. *See Caterpillar*, 15 BNA OSHC at 2178; *Pepperidge Farm, Inc.*, 17 BNA OSHC 1993, 2001 (No. 89-0265, 1997); *Kaspar*, 18 BNA OSHC at 2185.

Based on the record evidence, Chairman Railton agrees that in addition to the low gravity of recordkeeping violations in general, the injuries and illnesses that went unrecorded here were relatively minor. As the judge stated, "[e]ven under the Secretary's theory of the case, Respondent reported major injuries to Workers' Compensation as well as to OSHA while only the more marginal, or less serious injuries went unreported." Accordingly, based on all of the section 17(j) factors, Chairman Railton would affirm the judge's penalty assessment of a single

grouped penalty of $70,000 for Jindal's eighty-two willful recordkeeping violations.

Commissioner Rogers' Views

It is undisputed that the judge correctly affirmed separate violations for each of Jindal's separately cited recordkeeping errors, and his rulings to that effect are not on review. *Eric K. Ho*, 20 BNA OSHC at 1370; *Kaspar Wire Works, Inc.*, 18 BNA OSHC at 2185; *Caterpillar, Inc.*, 15 BNA OSHC at 2173. Both commissioners also agree that the record evidence and applicable law support the judge's characterization of the eighty-two recordkeeping violations he affirmed as willful. Commissioner Rogers believes, however, that the assessment of a single $70,000 penalty for the eighty-two affirmed willful violations is precluded by the OSH Act's penalty provisions. Rather, once having found eighty-two separate willful violations, the Commission *must* assess a penalty of at least $5,000 for each such violation.

As originally passed, the OSH Act provided that an employer "may be assessed" a maximum $10,000 penalty for "each [willful] violation." 29 U.S.C. § 666(a). Unlike the provision pertaining to serious violations, which prescribed that a penalty of up to $1,000 "*shall* be assessed[,]" there was no minimum penalty required for a willful violation. 29 U.S.C. § 666(b) (emphasis added). In 1990, Congress revised the OSH Act's penalty provisions by increasing the penalty amounts for all violations sevenfold, and establishing a minimum penalty for willful violations as follows.

> Any employer who willfully or repeatedly violates the requirements of section 654 of this title,

> any standard, rule or order promulgated pursuant to section 655 of this title, or regulations prescribed pursuant to this chapter, may be assessed a civil penalty of not more than $70,000 for each violation, *but not less than $5,000 for each willful violation.*

Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 3101 (1990), 29 U.S.C. § 666(a) (emphasis added). Accordingly, this case presents, for the first time, the question whether the Commission may now assess an aggregate penalty for multiple affirmed violations that amounts to less than $5,000 for "each [willful] violation."

The fundamental principle of statutory construction is that statutory language is to be construed according to its plain meaning. *Caminetti v. United States*, 242 U.S. 470, 485 (1917). When the language is plain, "'the sole function of the courts . . . is to enforce it according to its terms"' unless the result would be "absurd." *Hartford Underwriters v. Union Planters*, 530 U.S. 1, 6 (2000) (citations omitted). Thus, the first step in statutory construction is the wording of the statute itself which, if unambiguous, obviates reliance on legislative history or other external sources. *E.g., Consumer Product Safety Commission v. GTE*, 447 U.S. 102, 108 (1980) ("starting point for interpreting a statute is the language of the statute itself . . . [which,] absent a clearly expressed legislative intention to the contrary, . . . must ordinarily be regarded as conclusive"); *Arcadian Corp.*, 17 BNA OHSC 1345, 1347 (No. 93-3270, 1995) ("'[i]n a statutory construction case, the beginning point must be the language of the statute, and when a statute speaks with clarity to an issue[,] judicial inquiry into the statute's meaning, in all but the most

extraordinary circumstances, is finished"' (citations omitted)), *aff'd* 110 F.3d 1192 (5th Cir. 1997).

Commissioner Rogers would find that the words "not less than $5,000 for each willful violation" mean just that. *See Connecticut Nat. Bank v. Germain*, 503 U.S. 249, 254 (1992) (explaining that Congress "says in a statute what it means and means in a statute what it says"). In her view, these words are unambiguous and can only be read to require that at least $5,000 must be assessed for each affirmed willful violation. *See Kaspar Wire Works Inc. v. Secretary*, 268 F.3d 1123, 1130 (D.C. Cir. 2001) (finding that "plain language of the Act could hardly be clearer" that per-instance penalties are "consistent with the general principle that each violation of a statutory duty exposes the violator to a separate statutory penalty").

The legislative history emphatically supports this interpretation, clarifying that "[i]n order to ensure that the most egregious violators are in fact fined at an effective level, the conferees . . . adopted a mandatory minimum penalty of $5,000 for a willful violation of the OSH Act . . . [a]s a penalty floor that is not intended to become a penalty ceiling." H.R.Rep. No. 101-881, *reprinted in* 1990 U.S.C.C.A.N. 2050, 2393-94. The seven-fold increase in all penalties exceeded the three-fold increase that would have been sufficient to keep pace with inflation, as the larger increase was deemed necessary to effectuate the "stated purpose" of the OSH Act. *Id.* at 2393. *See U.S. ex rel. Chandler v. Cook County*, 277 F.3d 969, 978 (7th Cir. 2002) (finding that "[i]t could not be more clear that Congress, in adopting [False Claims Act penalty enhancement], addressed the situation with careful precision as to what sort of damage scheme was necessary to achieve the goals of the statute").

Congress also specifically contemplated the effect of the penalty increase in the context of willful recordkeeping violations, noting that "the mandatory minimum penalty adopted by the conferees targets the most extreme violators[,]" which includes employers who "knowingly and intentionally violate the recordkeeping and reporting requirements. . . ." H.R.Rep. No. 101-881, *reprinted in* 1990 U.S.C.C.A.N. at 2393-94. The potential for significant penalty enhancement of willful per-instance recordkeeping violations would have been apparent, as the Secretary's per-instance recordkeeping citations in *Caterpillar, Kohler, Inc.*, 16 BNA OSHC 1769 (No. 88-237, 1994); *Hern Iron Works, Inc.*, 16 BNA OSHC 1206 (No. 89-433, 1993); *Pepperidge Farm*; and *Kaspar Wire Works* all predated passage of the Omnibus.[5] *See also* 136 CONG. REC. S15776 (daily ed. Oct. 18, 1990) (statement of Sen. Hatch) (acknowledging that "OSHA, under its egregious policy, penalized several businesses in the multimillion dollar range").

Commissioner Rogers respectfully takes issue with her colleague's suggestion that the conferees' contemplation of a "settlement" exception to the minimum penalty

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[5] Commissioner Rogers also notes that the Commission and courts have routinely referred to the amended penalty amounts as if there were no question that they establish a $5,000 minimum willful penalty. *See MJP Constr. Co.*, 19 BNA OSHC 1638, 1649 (No. 98-0502, 2001) (referring to 29 U.S.C. § 666(a) "which mandates a minimum penalty of $5000 for a willful violation"); *Worldwide Mfg. Inc.*, 19 BNA OSHC 1023, 1024, 1026 (No. 97-1381, 2000); *Arcadian*, 17 BNA OSHC at 1349 ("referring to Omnibus, which "establish[ed] a $5,000 minimum penalty for willful violations"); *Reich v. Sabia Co.*, 90 F.3d 854, 859 (3rd Cir. 1996) (noting that 1990 amendment changed "statutory landscape" "by requiring a $5,000 minimum penalty for *willful* violations") (emphasis in original).

undercuts the mandatory applicability of the minimum in a litigated case. As the conferees recognized, the settlement comments concerned "OSHA's existing [settlement] authority . . . [as] [t]he conferees d[id] not intend to deprive the agency of [its] flexibility to settle cases. . . ." H.R.Rep. No. 101-881, *reprinted in* 1990 U.S.C.C.A.N. at 2394. The Secretary's *exclusive* settlement authority, including mitigation of penalties pursuant to settlement, is derived from her unique prosecutorial role. *Cuyohoga Valley Railway Co. v. United Transportation Union*, 474 U.S. 3, 7 (1985) ("[a] necessary adjunct of [the Secretary's sole] power is the authority to withdraw a citation and enter into settlement discussions with the employer") (citation omitted); *Donovan v. OSHRC (Mobil Oil)*, 713 F.2d 918, 927 (2nd Cir. 1983) (only Secretary has "unfettered discretionary authority to withdraw or settle a citation . . . or to settle, mitigate or compromise any assessed penalty"). Therefore, any exception, by its terms and by virtue of the Secretary's prosecutorial authority, would apply only to the Secretary and only in the context of settlements. *See Brooks Well Servicing Inc.*, 20 BNA OSHC 1286, 1288-89 (No. 99-0849, 2003) (noting general rule of statutory construction that "exceptions are to be narrowly construed") (citations omitted).

In agreement with her colleague, Commissioner Rogers acknowledges the Commission's statutory duty to assess an "appropriate" penalty based on the evidentiary record. 29 U.S.C. § 666(j), § 17(j). In her view, however, a focus on the Secretary's egregious/willful policy factors to determine whether per-instance penalties are appropriate for affirmed per-instance violations sidesteps the statutory issue. Such an approach "splits the baby" by dividing per-instance citation authority into two distinct analytical

questions: whether the cited standard/regulation can be read to support per-instance citations, and whether the record evidence sufficiently supports the Secretary's "willful plus" criteria to warrant individual penalties. Regardless of the permissibility of assessing a single grouped penalty for individually cited and affirmed violations, the amended Act simply precludes the assessment of *any* penalty that does not amount to at least $5,000 for each affirmed willful violation. This is consistent with the Commission's corollary limitation precluding assessment of a penalty exceeding the statutory maximum for a single violation, even were the Commission to find the maximum permissible penalty inadequate.

Nonetheless, in contrast to her colleague, Commissioner Rogers would find that assessment of a separate penalty for each of Jindal's willful recordkeeping violations is reasonable in the circumstances of this case, and satisfies the four section 17(j) penalty criteria as well as those the Secretary has articulated in her egregious/willful policy. As with all recordkeeping violations, the Commission classifies these violations as low gravity. However, Jindal's abysmal error rate that averaged approximately seventy percent over three years, in conjunction with a recordkeeping program specifically designed and implemented to under record, represents a level of bad faith that clearly justifies the Secretary's lawful exercise of her discretion to cite these violations separately and the penalties that statutorily flow from it.

Commissioner Rogers also rejects the notion that the statutorily prescribed minimum penalties here would be extraordinary. Under the Act's original penalty scheme, the Commission assessed an aggregate penalty of $210,500 for the 342 willful recordkeeping violations in

Kaspar, amounting to an average of $615.49 per violation. A seven-fold increase in that amount would yield a per violation penalty of $4,308.43. In *Pepperidge Farm*, the Commission assessed a penalty of $289,603 for the 176 willful recordkeeping violations, amounting to an average of $1645.47 per violation. A seven-fold increase in that amount would yield a per violation penalty of $11,518.29. Here, a $5,000 penalty for each of Jindal's eighty-two affirmed willful violations would yield a total penalty of $410,000, an amount well within the range of previously assessed willful penalties. In view of the mandatory minimum, and the documented Congressional intent to effectuate the "stated purpose" of the Act with a significant penalty increase, Commissioner Rogers would find that the judge exceeded his authority by assessing a single penalty that failed to amount to a dollar value equal to, or greater than, the $5,000 statutory minimum for each affirmed willful violation. *Cf. U.S. v. ITT Continental Baking Co.*, 420 U.S. 223, 229 n.6 (1975) (noting that where statute prescribes no minimum penalty and permits, though does not require, penalties assessed as a series of daily violations rather than a single violation, trial judge's penalty assessment reviewed for abuse of discretion).

2002 O.S.H.D. (CCH) P 32580

OCCUPATIONAL SAFETY HEALTH
REVIEW COMMISSION
SECRETARY OF LABOR, Complainant
v.
SAW PIPES USA, INC., and its successors, Respondent

OSHRC Docket No. 01-0422
FINAL ORDER DATE: July 1, 2002

Appearances:

For the Complainant: Raquel Tamez, Esq., Madeleine Le, Esq., Office of the Solicitor, U.S. Department of Labor, Dallas, Texas

For the Respondent: Thomas H. Wilson, Esq., Julianne Merten, Esq., Michael J. Muskat, Esq., Vinson & Elkins, LLP, Houston, Texas

Before: Administrative Law Judge: James H. Barkley

DECISION AND ORDER

This proceeding arises under the Occupational Safety and Health Act of 1970 (29 U.S.C. Section 651 et seq.; hereafter called the "Act").

Respondent, Saw Pipes USA, Inc., and its successors (Saw), at all times relevant to this action maintained a place of business in Baytown, Texas, where it was engaged in manufacturing seamless welded line pipe (Tr. 272, 286). Respondent admits it is an employer engaged in a business affecting commerce and is subject to the requirements of the Act.

On July 27, 2000 the Occupational Safety and Health Administration (OSHA) began an inspection of Saw's

Baytown, Texas work site. As a result of that inspection, Saw was issued a Willful citation alleging 67 violations of § 1904.2(a). The citation alleges 66 instances in which Saw failed to list recordable injuries or illnesses on its OSHA 200 form. Item 67 alleges that 16 injuries or illnesses were incorrectly recorded. Penalties of $8,000.00 per instance were proposed. By filing a timely notice of contest Saw brought this proceeding before the Occupational Safety and Health Review Commission (Commission).

On January 22-23, 2002, a hearing was held in Houston, Texas. Pursuant to a joint statement of the parties filed at the hearing, the Secretary withdrew items 27 and 67 (subpart 16), and Saw withdrew its contest to the recordability of all but 18 of the 66 failures to record and all but 5 of the 16 items allegedly reported incorrectly. Saw continued to contest the classification of the citation as willful, and the proposed penalties. During the hearing, the Secretary also withdrew item 17 of Willful citation 1 (Tr. 157), and Saw withdrew its contest as to the recordability of items 29, 34, 38 and 49 and 63 (Tr. 146-148). Following the hearing, Complainant withdrew three of those items, numbers 29, 34, and 63 (Complainant's post-hearing brief, p. 37, 38, 47). Finally, in its post hearing brief, Saw withdrew its notice of contest to items 11 and 20 based on the testimony presented at the hearing (Respondent's post-hearing brief, p. 2). The parties have submitted briefs on the issues remaining in dispute and this matter is ready for disposition.

Facts

Robert Murphey, a certified industrial safety technician, has been Saw's safety manager since May 1998 (Tr.

64, 216; Exh. C-245). Murphey testified that, in addition to filling out the OSHA 200 logs, he is responsible for responding to and investigating all accidents and injuries that occur at the Saw facility (Tr. 65, 80-81). Plant managers and supervisors are instructed to inform him of injury accidents (Tr. 66-68). If Murphey is not in the plant, security is to be notified (Tr. 67). Security is instructed to notify Murphey, via pager or by way of a patrolman's report, of all accidents and injuries which occur outside of his shift (Tr. 69-71). Murphey testified that Saw's accident policy requires that all injuries be reported (Tr. 71, 113). Murphey testified that the reports are not always submitted in a timely manner, and that he has complained about the problem to his supervisor, Mr. Jones, to the plant manager, Mr. Turnipseed, and to the chief executive officer, Mr. Bhargava (Tr. 115).

Carroll Caudill, Saw's maintenance manager, and Kurt Brodd, Saw's plant manager, both testified that when a Saw employee is injured, he notifies his supervisor. If required, medical treatment is immediately sought for the employee (Tr. 46, 160). Brodd testified that Robert Murphey is then contacted (Tr. 160). Where a reportable injury occurs, the supervisor fills out an accident or injury report which is submitted either to Robert Murphy, or to Murphey's supervisor, Gary Jones (Tr. 45-48, 58, 161). Brodd testified that it is Saw's policy to fill out an accident report in all cases (Tr. 162). Caudill, however, testified that reports are not always filled out for minor injuries (Tr. 58). Both Brodd and Caudill admitted that there are times when they have to be reminded to get a report to Murphey (Tr. 48, 56-57, 163, 168). However, Brodd stated that he was not aware of any accidents that were never reported to Mr. Murphey (Tr. 164).

Caudill testified, if an employee's injury is serious enough to merit a trip to the hospital, the employee must obtain a doctor's release before returning to work (Tr. 53). According to Caudill, the release is returned to the personnel department (Tr. 53). Caudill was not aware of any instances where an employee returned to work without going through personnel (Tr. 54). Dr. Jerry McShane, owner of the San Augustine Industrial Clinic, where Saw employees have been treated since early 1999, testified that accident reports, which include Return to Work (RTW) restrictions, are faxed to Saw in virtually every case (Tr. 452-53, 468). Dr. Carl Davis, a physician associated with BayCoast, which provided patient care for Saw's employers in 1998, testified that it was the practice to fax a copy of any work restrictions to Saw (Tr. 409-10). Murphey testified that because it is his job to coordinate any work restrictions an employee might have as a result of his or her injury, any paperwork documenting physician imposed work restrictions comes to him (Tr. 75, 124).

In addition to incident reports from supervisory personnel and plant security, and RTW forms from treating physicians, Murphey receives copies of the logs from the on site clinic on a monthly basis (Tr. 75, Exh. C-248, C-249, C-250). If an employee visits the on-site clinic as a result of his or her injury, the employee is required to sign in on the clinic log (Tr. 73). Murphey testified that he uses the nurse's sign in logs and any incident reports to assure that the OSHA 200 log is correct (Tr. 112).

Finally, Murphey testified that he and Gary Jones review medical bills for employees who are referred to the off-site clinic. It is his job to verify any medical expenses billed before they are paid (Tr. 72, 121).

Alleged Violations

Knowledge. Initially, this judge notes that all of the cited violations were discovered during a review of records obtained, considerably after the fact, in the course of the OSHA investigation. The records reviewed were in Saw's control or were contained in medical records controlled by Saw's agents. Such documents were available for the review of Saw's safety management at any time (Tr. 407, 469). Thus I find that even if Saw's safety managers lacked specific knowledge of any of the contested injuries, they could, with the exercise of reasonable diligence, have known of any medical treatment provided or work restriction imposed on any of the employees named in the citations. For this reason, Saw's constructive knowledge of the individual violations will not be further discussed.

Willful citation 1, item 5 alleges that on March 2, 1998, Edward Giering sprained his left knee at Saw's facility. Complainant alleges that the sprain resulted in work restrictions and should have been, but was not recorded (Joint Statement, p. 1, Exh. C-12).

After spraining his knee Giering visited the Bay Coast Medical Center, where the knee was splinted in a brace supported with metal rods, which he was to wear for seven days (Giering Depo., p. 25). Giering returned to work with instructions to restrict the use of his leg, and to refrain from climbing, bending or stooping (Exh. C-12). In a deposition given on February 26, 2002, Giering, a tack welder, testified that he was instructed at the clinic to remain seated, and to keep his leg elevated (Giering Depo., p. 12). Giering stated that [he] tried doing his job sitting the first day, but was unable to perform his regular duties in that position (Giering Depo., p. 12-13). Giering testified

that he was told that he "needed to be up there," and, believing his job was on the line, he resumed his duties despite his prescribed work restrictions.

The U.S. Department of Labor, Bureau of Labor Statistics publication, *Recordkeeping Guidelines for Occupational Injuries and Illnesses*, the "Blue Book" states that:

> *Lost workday cases involving days of restricted work activity* are those cases where, because of injury or illness, (1) The employee was assigned to another job on a temporary basis, or (2) the employee worked at a permanent job less than full time, or (3) the employee worked at his or her permanently assigned job but could not perform all the duties normally connected with it.
>
> Restricted work activity occurs when the employee, because of the job-related injury or illness, is physically or mentally unable to perform *all or any part* of his or her normal assignment during *all or part* of the normal workday or shift. The emphasis is on the employee's *inability* to perform normal job duties over a normal work shift.

(Exh. C-278, p. 48).

Saw argues that Giering was not unable to perform his job, because, at least after his first day back, he was able to stand on his braced left leg throughout his shift. Giering admitted that, because he believed that he would lose his job if he wasn't up on the line, he chose to ignore the physician's recommended work restrictions after the first day. This judge believes it would set a poor precedent to hold that the recordability of an injury may be based

solely on an employee's behavior, where such employee acts under pressure from his employer to return to his normal duties against the advice of his physician. *See*, item 32, in which on February 2, 1999 the same employee reported to OccuCare Industrial Medicine Clinic, with "persistent" left ankle sprain, after ignoring the physician's work restrictions and returning to full duty after a January 15, 1999 sprain, again fearing the loss of his job (Giering Depo. p. 24; Tr. Exh. C-96).

Because Mr. Giering was unable to perform his normal job duties without disregarding the advice of his physician, this injury was recordable.[1] Item 5 is affirmed.

Willful citation 1, item 21 alleges that on September 24, 1998, Craig Brodd suffered a contusion to his forearm at Saw's facility. Complainant alleges that the contusion required medical treatment and should have been, but was not recorded (Joint Statement, p. 1, Exh. C-57, C-58).

Medical Records from the BayCoast Clinic indicate that Brodd reported to the clinic in the early hours of September 25, where ice and Tylenol #3 were prescribed (Exh. C-58). Brodd visited Saw's on-site clinic later in that day, at which time Helen Stipe, the nurse on duty, examined him and made a note, Tylenol #3 TPD Q4H PRN, under the heading "Medications" (Exh. C-57). Complainant introduced no

[1] This judge takes notice that, in a February 6, 1998 Compliance Letter, the Secretary interpreted medical treatment to include the use of casts, splints and/or orthopedic devices designed to immobilize a body part. Though this case was characterized as a restricted work activity case, it was also recordable as requiring medical treatment.

evidence from which this judge might ascertain the meaning of this notation.

The Blue Book states that the administration of a single dose of prescription medication on a first visit for a minor injury or discomfort is generally considered first aid treatment, and need not be recorded if the injury does not involve a loss of consciousness, or restriction of work or motion (Exh. C-278, p. 43). In the absence of any evidence that more than one dose of Tylenol #3 was prescribed, this judge cannot find that the cited injury was recordable. This item is vacated.

Willful citation 1, item 23 alleges that on September 29, 1998, Alberto Arredondo reported to the BayCoast Clinic complaining that a piece of metal had struck his right eye while he was working at Saw's facility. Complainant alleges that the resulting corneal abrasion required medical treatment and resulted in work restrictions which should have been, but were not recorded (Joint Statement, p. 2, Exh. C-63).

BayCoast's records indicate that Arredondo's vision was unaffected by the incident, however, Neosporin ophthalmic solution and an eyepatch were applied to Arredondo's eye (Exh. C-63). The physician on duty, Richard Trifiro, then released Arredondo for work with instructions to refrain from driving any equipment (Exh. C-63). Arredondo returned for observation the following day, at which time Dr. Trifiro, who was unable to visualize a foreign body in Arredondo's eye, referred him to an ophthalmologist.

Complainant failed to introduce any evidence indicating that Mr. Arredondo was ever diagnosed with an injury requiring treatment beyond a single dose of Neosporin

ointment, or that the eyepatch Arredondo was required to wear interfered with the performance of his duties. Because the evidence does not establish that Mr. Arredondo suffered a recordable injury, item 23 is vacated.

Willful citation 1, item 31 alleges that on December 22, 1998, Edward Giering suffered an injury to his groin while working at Saw's facility. Complainant alleges that the groin injury resulted in work restrictions and should have been, but was not recorded (Joint Statement, p. 2, Exh. C-93).

In his February 26, 2002 deposition, Giering testified that Gary Jones sent him to the on-site nurse, and subsequently had Ray Snell, Robert Murphey's assistant, take him to the San Augustine Industrial Clinic (Giering Depo., p. 15-16). Giering returned to work with instructions to refrain from repetitive lifting until January 5, 1999 (Exh. C-93). Prior to his injury Giering was employed in the quality assurance and compliance department. Part of his job, which occupied approximately an hour and a half each day, was to move 20 to 25 pound samples of cut steel piping used in expansion rate testing (Giering Depo., p. 14-18). After the injury, Giering could no longer lift the samples, and was strictly limited to performing testing (Tr. 17-19).

As noted above, where the employee can still work at his or her permanently assigned job but cannot perform all the duties normally connected with it, that injury involves restricted work activity. In this case, Mr. Giering, because of his job-related injury was physically unable to perform a part of his normal assignment during part of the normal workday or shift. The injury was recordable, and this item is affirmed.

Willful citation 1, item 32 alleges that on January 15, 1999, Edward Giering sprained his left ankle while working at Saw's facility. Complainant alleges that the ankle injury resulted in work restrictions and should have been, but was not recorded (Joint Statement, p. 2, Exh. C-95).

At his February 26, 2002 deposition, Giering testified that he was taken to the San Augustine Clinic on Gary Jones' instructions (Giering Depo., p. 21). Giering returned to work the same day with instructions to avoid excessive bearing of weight on his left foot, squatting, and climbing (Exh. C-95). Giering testified that his job required him "[t]o climb up to the scope and to the ID and OD welders" (Giering Depo. p. 24). Giering testified that his supervisor, Hank Gosnell, implied that Giering would lose his job if he could not perform the duties associated with it; Giering stated that he ignored the medical restrictions (Giering Depo. p. 24). On February 2, 1999, Giering visited the OccuCare Industrial Medicine Clinic, where he was diagnosed with "persistent" left ankle sprain. Giering was provided with an ankle brace and instructed to avoid excessive weight bearing on his left foot until further notice (Exh. C-96).

The record establishes that Giering could not perform his normal work activities without disregarding the restrictions imposed by his physician. He ignored those restrictions because he feared for his job, not because he felt the restrictions were unnecessary and, in fact, his injury persisted. For the reasons set forth in item 5, this judge finds that item 32 was recordable. This item is affirmed.

Willful citation 1, item 41 alleges that on March 23, 1999, Richard Lee strained his lower back while working at Saw's facility. Complainant alleges that the injury resulted in work restrictions and should have been, but was not recorded (Joint Statement, p. 2, Exh. C-120).

At the hearing, Lee testified that Robert Murphy took him to the doctor, where he was provided with samples of 850 mg. Motrin and pain killers. X-rays were taken and Lee was given instructions for physical therapy (Tr. 251-52; Exh. C-120). Lee was allowed to return to work with restrictions; he was not to engage in excessive climbing, squatting or lifting of over 25 pounds (Tr. 252; Exh. C-120). After an April 7, 1999 follow-up appointment, Lee received instructions to remain on light duty until April 12, 1999 (Exh. C-120). Lee testified that his regular duties included helping out in other departments as needed. Lee testified that he helped the grinders at the expander on a daily basis (Tr. 255). Lee stated that, while helping out, he was required to squat, climb and lift over 25 pounds (Tr. 255). It was while he was helping out that he hurt his back (Tr. 254). Lee stated that his actual position was hydro tester/operator. That position does not require climbing, squatting, or lifting, and Lee was able to continue working as a hydro tester after his injury (Tr. 253-54).

Mr. Lee worked regularly in other departments, helping out on a daily basis. Because he was regularly assigned to assist the grinders at the expander, that duty was part of his normal job. Lee's inability to continue assisting in the expander department until his release from light duty on April 12, 1999 constitutes a recordable work restriction. This item is affirmed.

Willful citation 1, item 44 alleges that on April 8, 1999, Bobby Sindel suffered smoke inhalation while fighting a fire at Saw (Sindel Depo. p. 5-6; Exh. C-125, C-126). Complainant states that smoke inhalation is a recordable occupational illness which should have been, but was not recorded.

Sindel reported to Saw's in-house clinic on April 8, complaining of chest congestion and coughing. The nurse on duty reported that Sindel's throat was raw, but that his chest sounds were clear (Exh. C-125). Sindel was transported to OccuCare Clinic, where he was examined, and released for work without further treatment (Exh. C-125).

The Blue Book defines "occupational illness" as:

> Any abnormal condition or disorder . . . caused by exposure to environmental factors associated with employment. It includes acute and chronic illnesses or diseases which may be caused by inhalation, absorption, ingestion or direct contact.

Illnesses are to be listed in specific columns, by category. The relevant category in this case is:

> 7c. *Respiratory conditions due to toxic agents.* Examples: Pneumonitis, pharyngitis, rhinitis or acute congestion due to chemicals, dusts, gases or fumes; . . . .

The record does not establish that Sindel contracted an acute or chronic abnormal condition or disorder from the single exposure to smoke. Neither the in-house nurse, nor the physician at OccuCare reported finding any chest congestion (pneumonitis), or swelling of the throat (pharyngitis) or nasal passages (rhinitis). Because the

Secretary failed to prove that Mr. Sindel was diagnosed with a recordable occupational illness, this item is vacated.

Willful citation 1, item 47 alleges that on June 7, 1999, Saw employee Alejandro Dominguez suffered a corneal abrasion when debris flew into his left eye while he was grinding (Tr. 151; Exh. C-131, C-132). Complainant maintains that Dominguez received medical treatment, making the injury recordable.

Dominquez testified that after his injury, the on-site nurse flushed his eye (Tr. 151). The nurse noted that she provided Dominguez with Cortisporin ophthalmic solution and an eyepatch (Exh. C-131). Robert Murphey then drove Dominguez to OccuCare (Tr. 152). The attending physician's notes indicate that he anesthetized the eye, removed a foreign body, and dosed Dominguez' eye with Blephamide, listed in the Physician's Desk Reference as a prescription medication. Dominguez was provided with an eyepatch and released with a monocular vision restriction (Tr. 132; Exh. C-132). Dominguez testified that when the discomfort did not subside the following day, Mr. Murphey took him back to the clinic, at which time the doctor checked his eye again, and again dosed it with Blephamide, before sending him to an ophthalmologist (Tr. 153; Exh. C-132).

The Blue Book states that the removal of foreign bodies embedded in the eye is almost always a recordable injury (Exh. C-278, p. 43). In this case, it is more likely than not that the debris was embedded in Dominguez's eye, as the on-site nurse was unable to remove it with flushing. Moreover Dominguez was treated on multiple visits with the prescription medication, Blephamide. Injuries

requiring multiple doses of prescription medications are recordable (Exh. C-278, p. 43). Item 47 is affirmed.

Willful Citation 1, item 48 alleges that on June 25, 1999, James Jones suffered a sprained left ankle (Exh. C-133, 134). Jones' injury required a brace, which resulted in work restrictions including instructions to avoid excessive standing, weight bearing on the left foot, and climbing (Exh. C-134).

This judge takes note that in a February 6, 1998 Compliance Letter, the Secretary interpreted medical treatment to include the use of casts, splints and/or orthopedic devices designed to immobilize a body part. The Secretary's interpretation is reasonable, and this item is affirmed.

Willful Citation 1, item 67(5) alleges that on June 25, 1998 Marco Contresas strained his back while lifting ground wires (Exh. C-199, C-200). Contresas was treated at Bay Coast Clinic and was released for work with restrictions consisting of no climbing, bending, stooping, or lifting of any weight in excess of 10 pounds for five to seven days (Exh. C-201).

The injury report that Robert Murphey filed with Texas' worker's compensation states that Contresas, a welder, was performing his regular job when injured (Exh. C-198). This judge finds it more likely than not that Contresas' restrictions would prevent him from stooping or bending to lift ground wires, a part of his normal duties, and the very activity which caused his injury. Item 67(5) is affirmed.

Willful Citation 1, item 67(8) alleges that on March 11, 1999 James Hedden, a welder, strained his right wrist

and hand while using a wrench. Hedden was treated, his wrist splinted and he was allowed to return to work with restrictions (Exh. C-213, C-214, C-215, C-216). Hedden was instructed to avoid excessive use of his right hand and repetitive lifting of 20 pounds or more (Exh. C-216). Hedden did not testify, and in the absence of any evidence as to his normal duties, this judge cannot find that he was unable to perform his job while observing the listed restrictions. Item 67(8) is vacated.

Willful Citation 1, item 67(11) alleges that on March 9, 2000, Gary Cooper, a millwright, cut his right thumb (Exh. C-226). After receiving stitches and a tetanus shot at the clinic, Cooper returned to work with restrictions including instructions to avoid excessive pressure and/or use of his right hand, and to keep the wound dry and clean (Tr. 394-95; Exh. C-226). At the hearing, Cooper testified that his job requires that he use power and hand tools, and that he is right-handed (Tr. 395). Cooper testified that he could perform most of his job duties using his left hand; however, he could not operate a torch, which required him to use his thumb (Tr. 397).

Using a torch was part of Cooper's job, and the restriction which prevented him from full use of his right hand was recordable. This item is affirmed.

Willful Citation 1, item 67(13) alleges that on April 18, 2000, Michael Ellison, a welder, suffered a laceration to his right palm (Exh. C-230). After seeing the on-site nurse, Ellison went to the San Augustine clinic, where he was given stitches, and allowed to return to work with restrictions (Exh. C-231). Ellison was instructed to avoid excessive use of his right hand and to keep the wound dry and clean (Exh. C-232). On April 19, and again on April 28,

Ellison returned to San Augustine at which time the attending physician noted "no welding" on his Return to Work (RTW) form (Exh. C-232). Ellison was returned to full duty on May 2, 2000.

This judge finds it more likely than not that Ellison, a welder, would be unable to perform his normal duties with a medical restriction barring him from welding. Item 67(13) is affirmed.

Willful Citation 1, item 67(15) alleges that on [date missing] Don Schwartz suffered a foreign body to his right eye. After the foreign body was removed with an algar brush at the San Augustine clinic, Schwartz returned to work with instructions to refrain from excessive monocular vision (Exh. C-235). Schwartz did not testify at the hearing, and in the absence of any evidence as to his normal duties, this judge cannot find that he was unable to perform his job with restricted vision. Item 67(15) is vacated.

Willfulness

The Secretary maintains that Saw engaged in a deliberate pattern or under-reporting work place injuries in order to avoid being targeted for OSHA inspection. Complainant argues that Saw's practice of under-reporting is demonstrated by a drop in its lost workday injury and illness (LWDII) rate from 9.6 in 1996 to reported rates of 2.7, 3.1 and 4.2 in the following years, 1997, 1998, and 1999. Complainant points out that Saw's witnesses can recall no significant changes that would have impacted safety at the Saw plant during 1997 and the following years, and cannot account for the dramatic drop in the LWDII during that time. Complainant's witnesses, on the

other hand, testified that they believed the drop in the rate was the result of deliberate under-reporting of minor injuries pursuant to policy developed by Gary Jones. Complainant argues that its theory explains Jones' deliberate decision not to record injuries suffered by temporary laborers, and his decision to change Saw's Standard Industrial Classification (SIC) code in 1998.

Saw maintains that the drop in the LWDII, the failure to record minor reportable injuries and injuries to temporary workers, and the change in Saw's SIC code were all attributable to unrelated misinterpretations of OSHA requirements. Saw argues that any and all misinterpretations of OSHA requirements were made in good faith. At no time did Saw intend to circumvent an OSHA inspection.

Facts

Charles Kutan is currently the production planning manager for Saw (Tr. 257). Kutan was originally hired in June 1995 to serve as Saw's human resources and safety director (Tr. 257-58). Kutan testified that, in that position, it was his responsibility, in addition to dealing with personnel issues, to investigate accidents and to maintain the OSHA 200 logs (Tr. 261). Kutan stated that he maintained the logs until mid-1997 (Tr. 261). According to Kutan, his experience prior to 1995 was in shipping (Tr. 267). In order to fulfill his new safety duties at Saw, he had to familiarize himself with OSHA regulations regarding recordkeeping by conferring with Saw's Workman's Compensation carrier, and by reading OSHA publications, including the 200 form and the Blue Book (Tr. 267-68; Exh. C-278). Kutan testified that it was his practice to list

recordable injuries on the OSHA 200 as they occurred (Tr. 266). Robert Whitmore, chief of OSHA's division of record-keeping requirements, testified that in 1996 Charles Kutan submitted an LWDII rate of 9.6 on the 1996 OSHA 196 Summary form, based on information contained in 1996 OSHA 200, the only complete year for which Kutan maintained the 200 form (Tr. 305).

Prior to joining Saw, **Gary Jones**, who is an attorney, was employed for 19 years as the employee relations representative at Brown & Root. As part of his job duties at Brown & Root, Jones dealt with a number of governmental agencies, including OSHA. He attended safety seminars, met with OSHA investigators, and responded to OSHA complaints (Tr. 182). During his tenure with Brown & Root, Jones occasionally reviewed the OSHA 200 logs (Tr. 200). He was familiar with the Blue Book (Tr. 200-01).

Jones took over as director of human relations at Saw in July 1997 (Tr. 181). Jones also acted as Saw's safety director, and his duties included ensuring compliance with OSHA reporting requirements (Tr. 206-07). In August 1997, Jones hired Ronnie Johnson to act as safety manager for Saw (Tr. 208). Jones testified that he chose Johnson because he was a medic, and was familiar with OSHA regulations (Tr. 208). Jones testified that he considered the OSHA 200 log to be Johnson's responsibility; however, at some point Jones became aware that Johnson was not keeping the log. Jones testified that, together, he and Johnson brought the log up to date (Tr. 209, 213). Jones testified that he never again consulted with Johnson about the recordability of any particular injuries (Tr. 215). According to Jones, Johnson completed and certified the 1997 OSHA 200 logs (Tr. 214; Exh. R-1). Jones, however, completed and certified the OSHA Form 196 Summary for

1997 (Tr. 207; Exh. C-276, p. 3). The LWDII rate Jones submitted for 1997 was 2.7 (Tr. 305).

Robert Murphey, who replaced Johnson as safety manager in 1998, testified that he was familiar with OSHA regulations and standards, including the Blue Book (Tr. 65). As Saw's safety manager, he was responsible for responding to accidents and injuries and for maintaining the OSHA 200 logs (Tr. 65, 116). Though Murphey reported directly to Jones, he testified that Jones did not instruct him in the correct means of completing the logs (Tr. 64, 111, 216). As noted above, Murphey used the nurse's sign-in logs and accident and incident reports to assure the accuracy of the OSHA 200 log (Tr. 112). Murphey stated that he made every attempt to follow up on accidents and incidents at the Saw facility in order to ascertain whether all recordable injuries had been reported (Tr. 139-40). Murphey maintained that if he failed to record an injury, it was either because the nurse failed to turn over forms specifying medical treatment or work restrictions, or because supervisors failed to turn in accident reports (Tr. 124-126). Murphey completed and certified the OSHA 200 logs for 1998 and 1999, and kept the logs for the first part of 2000 (Tr. 98, 106-107, 111). Mr. Murphey was aware that LWDII rates were used to target OSHA inspections, though he did not know exactly what rates would trigger an inspection (Tr. 131). The LWDII rates for 1998 and 1999 were 3.1 and 4.2, respectively (Tr. 305). During the first half of 2000, Saw's LWDII rate was 0 (Tr. 305).

Craig Wetherington was hired in May 1998 to ac as the safety director for Jindal Steel, a plate steel manufacturing facility located on the same 59 acre tract which houses Saw; both were part of an older USX steel mill

facility (*See, Secretary v. Jindal United Steel Corp. (Jindal)*, Docket No. 00-2231 [[petition for discretionary review pending before the Commission] Tr. 583).[1] Jindal produces the plate steel which Saw uses for producing pipe. The two companies share some common ownership; Saw Pipes holds stock in Jindal (*Jindal*, Exh. A, pp. 141, 595). Wetherington was told when he was hired that Jones was the administrator of the safety program for both Jindal and Saw pipes (*Jindal*, Exh. A, pp. 66, 126), and that he had dual responsibility to both Jindal's production manager and to Gary Jones (*Jindal*, Exh. A, pp. 49, 66-67, 76, 98-99, 113). Wetherington stated that Jones instructed him not to record any injuries which were not also reported to Texas Workers' Compensation (*Jindal*, Exh. A, pp. 65, 68, 77-80). Jones also specifically told Wetherington that injuries suffered by temporary laborers would be reported by the agency through which the laborer was employed, and that Wetherington was not to report those injuries (*Jindal*, Exh. A, p. 74). Wetherington testified that when he told Jones this did not conform to OSHA reporting guidelines; Jones told him he interpreted the guidelines differently (*Jindal*, Exh. A, pp. 74, 93). As a result, Wetherington did not report any injuries to temporary laborers; he did not do any follow up on temporary employees who had been injured (*Jindal*, Exh. A, p. 81). Wetherington testified that he filled out the OSHA 200 forms in accordance with instructions provided him by Gary Jones (*Jindal*, Exh. A, p. 68), but told Jones he did not believe the 200 log was being filled out correctly. Jones

[1] Pursuant to the joint motion of the parties portions of the Jindal transcript were admitted and made part of this record by this judge's January 18, 2002 Order. Prior testimony from Jindal is labeled Exhs. A through J.

told Wetherington that he interpreted OSHA regulations differently and that if Wetherington didn't want to record injuries according to his interpretation, Wetherington could find another job (*Jindal*, Exh. A, pp. 68-69, 555). Wetherington believed that Jones' intent was to misrepresent the number of accidents at the plant in order to evade inspections by OSHA by reporting a low LWDII (*Jindal*, Exh. A, pp. 109-10, 115-116).

Ronnie Johnson testified that Gary Jones maintained the OSHA 200 logs while he was employed at Saw (*Jindal*, Exh. E, p. 401). Johnson stated that he was aware that otherwise recordable injuries were not being recorded on the OSHA 200 logs in an attempt to keep the numbers down (*Jindal*, Exh. E, pp. 396, 402-03). According to Johnson, Jones would not record an injury if Saw paid the injured employee's medical costs in house rather than submitting a Workman's Compensation claim (*Jindal*, Exh. E, pp. 395-96). In addition, Johnson testified, he knew that Jones was not recording otherwise recordable injuries if those injuries were suffered by temporary employees (*Jindal*, Exh. E, p. 397).

Carl Davis, the Director of Occupational Medicine for the Jacinto Medical Group in Baytown Texas (Tr. 399), testified that in October 1998 he became aware that the Jacinto Medical Group supervised the Licenced Vocational Nurse (LVN) from BayCoast Medical Center who ran Saw's on-site medical facility (Tr. 400-01). On or about October 28, 1998, Davis visited the Saw facility, where he met with the LVN, Helen Stipe, Gary Jones and Robert Murphey (Tr. 402). During that visit, Davis testified, Jones took him aside and informed him that Saw " "did not have recordable injuries" (Tr. 403). Davis testified that he subsequently spoke with Jones two or three times a week

(Tr. 406). During those conversations, Jones often criticized Davis' decisions to restrict employees' work activities (Tr. 405). Davis testified that Jones specifically asked him to not to place employees under work restrictions (Tr. 445-46). Specifically, Davis stated:

> Well, in the course of reporting patient status to Mr. Jones and in conversations we had when he would call me, Mr. Jones was, many times, critical of the fact that restrictions had been placed on the patients' work activity. Some of them were less than friendly. They were generally critical if any restriction had been placed. He, on more than one occasion, asked me to write "No restrictions."

(Tr. 405). In December 1998, Saw terminated its contract with BayCoast (Tr. 405).[2]

Robert Whitmore testified that OSHA's programmed inspections are based on employer LWDII rates (Tr. 364). The OSHA Occupational Injury an Illness Data Collection form, which is mailed to employers, including Saw, informs those employers that the injury and illness data collected from them "will be used to focus OSHA activities" including inspections (Tr. 365; Exh. C-274, p. 2, C-275, p.

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[2] At the hearing, this judge disallowed Respondent's attempts to impeach Dr. Davis' credibility by introducing evidence of a professional disciplinary action that involved neither Saw, nor any Saw employees. Such evidence was deemed irrelevant and prejudicial (Tr. 434-35, 442). In an effort to circumvent this judge's ruling, Saw has attached to its brief documents detailing actions taken by the Texas State Board of Medical Examiners in 1999 (Saw's post hearing brief, Exh. D, E and F). Submission of those exhibits violates the spirit of this judge's ruling; Exhs. D, E and F are, therefore, stricken from the record and will be removed from Saw's brief.

2). The formula OSHA uses for targeting inspections changes frequently. For instance, in 1998, OSHA targeted employers for inspection if the employer's 1996 LWDII rate exceeded the average for its Standard Industrial Classification (SIC) code (Tr. 341). In 1999 OSHA used data from employers' 1997 OSHA form 196 injury summaries (Tr. 336). Employers with LWDIIs exceeding 16 were placed on OSHA's primary targeting list, while employees with LWDIIs between 10 and 16 were placed on the secondary list (Tr. 337,-339). In 2000, inspections were planned for employers reporting an LWDII of over 14 on their 1998 injury summaries (Tr. 330-31, 339). Employers reporting an LWDII between 8 and 14 were placed on a secondary list, and might or might not be inspected, depending on OSHA's workload (Tr. 331). Whitmore testified that in any given year, employers would not know what injury rate would trigger an inspection two years down the line (Tr. 340-41). However, employers with extremely low LWDII rates were "not even on [OSHA's] radar screen" (Tr. 364). According to Whitmore, OSHA has not targeted an employer with an LWDII of less than 4.6 since its inception,(Tr. 433-44).

SIC Codes. During 1995 and 1996, while Charles Kutan kept the OSHA logs, Saw listed its SIC code as 3317 Steel Pipe and Tubes (Tr. 269-70, 308; Exh. C-276, C-300). The description of the 3317 industrial code is: " "Establishments primarily engaged in the production of welded or seamless steel pipe and tubes and heavy riveted steel pipe from purchased materials." Examples of the manufactured product include "pipe seamless steel-mfpm." (Exh. C-300). Charles Kutan testified that Saw was, and is, in the business of producing welded line pipe (Tr. 272). Kutan could not recall specifically telling Gary Jones Saw's

SIC code, but stated that he would have shown him the paperwork, including the OSHA summaries on which the 3317 SIC code was set forth (Tr. 271, 293). Mr. Whitmore testified that during his formal interview with Dilip Bhargava, Saw's then president and CEO (Tr. 172), Bhargava told him that he believed that Saw fell under the 3317 industrial code (Tr. 391).

Whitmore testified that, in 1998, OSHA attempted to conduct a programmed inspection of Saw's facility based on Saw's 1996 LWDII rate, which at 9.55 exceeded the industry average of 5.6 for SIC 3317 (Tr. 308-09, 317-318). Gary Jones turned the OSHA inspectors away, claiming that Saw's SIC code was not 3317, but 3443 (Tr. 202-204, 232, 315, 318).[3] The description for SIC code 3443 Fabricated Plate Work (Boiler Shops) is: "Establishments primarily engaged in manufacturing power and marine boilers, pressure and nonpressure tanks, processing and storage vessels, heat exchangers, weldments and similar products, by the process of cutting, forming and joining metal plates, shapes, bars, sheet, pipe mill products and tubing to custom or standard design, for factory or field assembly." (Exh. C-301). Chuck Kutan testified that Saw never manufactured boilers, pressure or non-pressure tanks, heat exchangers and/or weldments (Tr. 272-273). Saw claims the 3443 classification was made in good faith, based on a bullet on the bottom of a second page listing possible sample products which includes "Pipe, large diameter: metal plate-made by plate fabricators." Though

[3] Robert Murphey claimed not to be familiar with SIC codes, but testified that when he was hired, and again in 1998 when Gary Jones turned the OSHA inspectors away, he was told Saw's SIC code was 3443 (Tr. 102-05).

Saw does fabricate large diameter pipe from steel plates, Saw does not fabricate metal plate. All its plate is purchased (Tr. 110). Whitmore testified that no reasonable person could have believed that 3443 was the applicable SIC for Saw (Tr. 349-50).

Temporary employees. Saw admits that injuries suffered by temporary employees were not recorded on its OSHA 200 Logs or figured into its LWDII rates.

Robert Murphey testified that he consulted the Blue Book (Tr. 132), which states in relevant part:

> If [a temporary laborer is] subject to the supervision of the using firm, the temporary help supply service contractor is acting merely as a personnel department for the using firm, and the using firm must keep the records for the personnel supplied by the service. If the temporary workers remain subject primarily to the supervision of the supply service, the records must be kept by the service. In short, the records should usually be kept by the firm responsible for the day-to-day direction of the employee's activities.

(Exh. C-278, p. 24). Murphey, however, testified that he believed injuries to temporary workers were recorded by Labor Ready, the personnel agency that supplied Saw's temporary laborers, because the Labor Ready representative, Gary Young, once asked him for a blank 200 log (Tr. 97-98, 110, 122).

Murphey also testified that he read the instructions for filling out the OSHA injury and illness data collection form in 1998 and 1999 (Tr. 135). The form asks employers to **"Tell us about your employees and the hours they worked."** The form directs the employer to estimate its

average number of employees by ""[adding] together the number of employees your establishment paid in every pay period during 1998 [and 1999]. Include all employees: full time, part time, temporary, seasonal, salaried and hourly," and divide the answer by the number of pay periods (Exh. C-274, C-275, p. 3). The form goes on to ask how many hours employees actually worked during the relevant years and directs the employer to "[i]nclude hours worked by salaried, hourly, part-time and seasonal workers, as well as hours workers subject to day to day supervision by your establishment (e.g. temporary help service workers) (Exh. C-274, C-275, p. 3). Murphey stated that he either "missed that part," or "just didn't get [it] down." (Tr. 136).

Saw argues that Murphey was not the only one who misunderstood the reporting requirements. Labor Ready, the staffing agency that provided laborers for Jindal Steel kept its own OSHA 200 log for laborers supervised by Jindal (*Jindal*, Exh. C, pp. 231-32, 562). In addition, after reviewing Chapter IV of OSHA's Blue Book, Gary Jones advised Jindal's safety manager, Craig Wetherington, not to record injuries to temporary laborers. Though Wetherington told Jones that he believed injuries suffered by temporary employees were recordable, Jones insisted that such injuries should be recorded by the staffing agencies that provided the laborers (*Jindal*, Exh. A, pp. 221-22; *Jindal*; Tr. 561-62, 588-90).

Discussion

The Commission has defined a willful violation as one "committed with intentional, knowing or voluntary disregard for the requirements of the Act or with plain indifference to employee safety." *Valdak Corp.*, 17 BNA OSHC

1135, 1136, 1993-95 CCH OSHD ¶ 30,759, p. 42,740 (No. 93-239, 1995), *aff'd*, 73 F.3d 1466 (8th Cir. 1996). Moreover, a series of disparate violations may be found to be willful if there is evidence that such violations are part of a deliberate pattern, practice, or course of conduct. *See, Kaspar Wire Works, Inc. (Kaspar)*, 18 BNA OSHC 2178, 2000 BNA OSHC ¶ 32,134 (No. 90-2775, 2000), *appeal filed*, No. 00-1392 (D.C. Cir. Sept. 26, 2000).

The Secretary maintains that Saw engaged in a deliberate pattern of under reporting in order to avoid being targeted for OSHA inspection. Saw maintains that the evidence in the record is insufficient to demonstrate Saw's motives, arguing that neither Gary Jones nor Robert Murphey knew or could have predicted the criteria OSHA would be using to target specific industries in any given year. However, any safety and health officer who knows that employers' LWDII are used to target inspections, would also know that an employer's chances of being inspected are reduced if it produces an extremely low LWDII. In any event, the Commission has held that he Secretary need not show that the employer had an evil or malicious motive to show willfulness. In other words, Complainant needn't prove *why* Saw engaged in the demonstrated practice of under-reporting. "The state of mind required for a willful violation need be only knowing, voluntary, or intentional." *Id.* at 2183-84. Complainant need only show that the demonstrated practice of under-reporting was deliberate. During the relevant time period, Saw failed to record 63.7% of all reportable cases on its OSHA 200. Of those cases that were reported, 40.6% were erroneously listed as involving no lost or restricted work

days.[4] The sheer number of unreported injuries in this case cannot be explained by simple negligence. Those numbers, when viewed in light of the testimonial evidence, discussed more fully below, are sufficient to establish that the comprehensive under-reporting of injuries and lost workdays in this case was knowing and intentional and, therefore, willful.

Charles Kutan was hired in 1995 to act as Saw's human resources and safety director. Though Kutan had no prior training in safety and health, and though he had dual responsibility for human relations and safety, Kutan managed to correctly determine Saw's SIC code, and to record injuries as they occurred. A month after Gary Jones took over as human resources director in 1997, he was able to hire a safety director, first Ronnie Johnson and then Robert Murphey, with whom he could effectively split the duties that Kutan previously handled alone. Jones, Johnson and Murphey all had considerable safety and health experience. They inherited a pre-existing reporting system under which plant managers and supervisors were to report injuries and accidents to the safety director. Additional procedures, which should have increased reporting accuracy, were instituted. An on-site clinic was established, where a Licenced Vocational Nurse (LVN) could evaluate injuries, and provide limited treatment. The on-site nurse kept a sign-in log, which the safety manager could use to double check his OSHA log. When injured employees were seen by a physician, Return To Work (RTW) forms detailing employees' work restrictions

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[4] These percentages reflect all injury cases occurring between January 1998 and mid-2000, adjusted to conform to this judge's ruling on the contested items as set forth above.

were faxed to Saw from the off-site clinic. Despite the increase in the number and expertise of safety personnel, however, the timeliness and accuracy in recording injuries plummeted after Jones took over the management of Saw's safety department. Neither Jones nor Saw provided any explanation for the drop in the LWDII on Saw's 1997 OSHA 196 summary, which was 2.7, down from 9.55 the year before. Reporting accuracy did not improve when Robert Murphey took over responsibility for the logs in May 1998. Though Murphey claimed to have made every attempt to follow up on accidents and incidents at the Saw facility in order to ascertain whether all recordable injuries had been reported, and maintained that he used available accident reports and the sign in logs from the on-site infirmary to ensure the accuracy of the OSHA 200 logs, injuries and lost workdays continued to be under-reported. LWDII rates of 3.06 and 4.18 were submitted for 1998 and 1999, respectively.

Given the reporting system available to Murphey, this judge cannot credit Saw's contention that he did not possess *actual* knowledge, either of the occurrence, or of the extent, of cited employee injuries. First, Saw points out that Murphey "relied heavily" on accident reports submitted from first line supervisors, reports which Saw maintains were infrequently filled out. Saw further argues that there was not enough information on the accident forms returned from the off-site clinic for Murphey to make a determination of recordability. Finally, Saw argues that the nurses' log, on which Murphey also relied, was incomplete and failed to provide Murphey with notice of cited injuries. Saw's arguments fail because, though there were lapses in reporting, there were so many redundancies in the way injuries were reported at Saw, it would have

been impossible for almost *two thirds* of reportable injuries to go unrecognized by the safety manager. For instance, Saw's justifications do not explain Murphey's failure to record:

Item 22. On September 28, 1998 Myron Ferguson suffered a laceration to his thumb. His supervisor filled out an incident report (Exh. C-60). Nurse Stipes saw Ferguson on-site, and after dressing the wound she referred him to BayCoast emergency. In her clinical notes Stipes noted "considerable" bleeding (Exh. C-61). The clinic log clearly reflects that Mr. Ferguson was sent to the emergency room (Exh. C-248, p. 4). Ferguson's wound was sutured, and his treatment was listed on the RTW form generated by BayCoast for Saw (Exh. C-62, p. 6). In this case, there was an incident report, a log entry indicating a referral to the emergency room and an RTW form stating that sutures, recordable medical treatment had been provided (Exh. C-278, p. 43). It is difficult to conceive how Murphey's failure to report this injury could have been anything other than intentional.

Item 40, Alan Edgar suffered a probable 2nd degree burn on March 22, 1999. Edgar reported the injury to Murphey on March 24; Murphey treated Edgar's burn for two days before taking him to the on-site clinic on March 26, after which Saw's nurse, Helen Stipe, treated the burn with repeated applications of a prescription antiseptic ointment (Exh. C-118). The log from the on-site clinic lists three visits by Alan Edgar; each listing contains a description of his injury and the medical treatment received (Exh. C-249, p. 5).

Saw is correct in stating that there was no accident report filed in this case. However, Murphey had actual

knowledge of this injury, having treated the victim himself and taken him to the clinic nurse. He had access to the log, which details multiple repeat visits to the clinic for antiseptic dressings. The Blue Book clearly states that the "[a]pplication of **ANTISEPTICS** during second or subsequent visit to medical personnel" is recordable (Exh. C-278, p. 43). Saw's explanations do not account for Murphy's failure to record this item.

Item 42, On April 2, 1999 Jose Garza suffered 1st and 2nd degree burns to his shoulder. Bob Murphey treated the injury before sending Garza to the on site clinic. Garza also visited the OccuCare clinic, where an accident report was generated, indicating that the burns were diagnosed as 3rd degree. Ms. Stipe continued to administer repeated applications of antiseptics until April 8 (Exh. C-121, C-122). Five separate visits to the on site clinic are listed in the clinic log; the record of each visit includes a description of the injury and the treatment administered (Exh. C-249, p. 6).

As in item 40, Murphey was shown to have actual knowledge of the unrecorded injury. Although the Blue Book clearly states that the "[a]pplication of **ANTISEPTICS** during second or subsequent visit to medical personnel" is recordable (Exh. C-278, p. 43), Murphey inexplicably failed to record this injury.

Item 51. On August 9, 1999 Reyes Garcia suffered a severe contusion to his right shin. Robert Murphey applied an ice pack to the site for 20 minutes before sending Garcia to the on-site clinic, where an additional ice pack was applied (Exh. C-142). After returning to work three days later, Garcia returned to the clinic no less than eight times for repeated treatments with ice and heat packs

(Exh. C-142, C-249, p. 10). Each of the eight entries on the clinic log refers to both the shin injury and the treatment provided (Exh. C-249, p. 10).

Again, Murphey had first hand knowledge of the occurrence of this injury, and the nurses log clearly details the course of Mr. Garcia's treatment. The Blue Book clearly states that the "application of hot or cold **COMPRESS(ES)** during second or subsequent visit to medical personnel" is recordable medical treatment (Exh. C-278, p. 43). Yet Murphey failed to record this item.

The evidence establishes by a preponderance of the evidence that Murphey had actual knowledge of each of the clearly recordable injuries discussed above. This judge can only conclude that his failure to record these injuries was intentional. The Secretary made no attempt to prove that each of the cited items demonstrates such patent indicia of willfulness, and this judge declines to examine each instance for such evidence. Because the Secretary has alleged a single pattern of under-reporting, this sampling of clearly recordable injuries, of which Murphey had first hand knowledge, and yet failed to record is material evidence that Saw engaged in a deliberate practice of under-reporting.

Saw's intentional failure to record injuries sustained by temporary laborers is also evidence of an intentional practice of under-recording. Saw argues that its practice reflected its employees' good faith misinterpretation of the OSHA guidelines referring to temporary workers, and so cannot, as a matter of law, be found willful. However, though it is true that a finding of willfulness is not justified where the employer had a good faith opinion that the violative conditions conformed to the requirements of the

cited standard, the Commission has held that the test of good faith for these purposes is an objective one. The employer's belief concerning a factual matter, or as here, concerning the interpretation of a standard, must have been reasonable under the circumstances. *Calang Corp.*, 14 BNA OSHC 1789, 1987-90 CCH OSHD ¶ 29,080 (No. 85-319, 1990). In this case it is abundantly clear that the temporary labor contractor with whom Saw dealt acted merely as a conduit to provide labor for Saw. Saw was responsible for the day-to-day direction of the employees' activities. According to the plain language of the Blue Book, Saw was the firm responsible for keeping the required OSHA injury and illness records. The fact that the temporary agency also recorded injuries sustained by its temporary workers did not affect Saw's duty under the standard. For Jones, who is an attorney, and who worked in the employee relations and compliance department at Brown & Root before joining Saw Pipes, to have interpreted the Blue Book in any other way is not only unreasonable, but incredible. Moreover, the record establishes that Jindal's safety manager, Craig Wetherington, was not only knowledgeable in safety and health matters but specifically told Jones that the supervising employer had a duty to record such injuries. Jones not only ignored Wetherington, but instructed him to continue underreporting Jindal's injuries or risk losing his job. Wetherington's testimony describes Jones' dealings with Jindal's safety personnel, but is strong evidence of state of mind, and of his bad faith in dealing with OSHA. Finally, Robert Murphey's claim to have "'missed" those portions of the OSHA forms that clearly instructed him to include temporary workers in his calculations is no more believable than Jones' misinterpretation of OSHA regulations and is not credited.

Finally this judge finds that Jones' inexplicable change of Saw's SIC code to the code for boiler shops constitutes additional evidence of bad faith. After reading the relevant SIC definitions, this judge agrees that no reasonable person, and certainly not a professional with Jones' experience in safety and health, could have believed that 3443 was the applicable SIC for Saw. Even if Saw is correct in arguing that Jones could not have known that changing the SIC code would affect the likelihood of an OSHA inspection, the fact remains that Jones actually turned an OSHA inspector away in 1998 on grounds that OSHA had the wrong SIC code.

This judge credits the testimony of complainant's witnesses, Craig Wetherington and Carl Davis, both of whom concluded, based on their dealings with Gary Jones, that Saw was pursuing a course of conduct intended to reduce the number of injuries reported to OSHA. Those witnesses have no stake in the outcome of this matter, and this judge finds their testimony compelling. When viewed together with the percentage of unrecorded injuries occurring during the relevant time periods, and the clear recordability of a number of those injuries, this judge can only conclude that Saw's failure to report and under-reporting of injuries was part of a pattern of deliberate, *i.e.* willful conduct.

Penalty

While the Secretary has often exercised her authority to group related violations and propose a single penalty for a number of related violations, she chose not to do so in this case. Rather the violations were assessed individually, at $8,000.00 apiece, resulting in an aggregate penalty of

$536,000.00. While it is clear that the Secretary may propose multiple penalties for separate violations of the recordkeeping standard, Commission review of the proposed penalty is *de novo*, and the judge has discretion to assess a single penalty if deemed appropriate. *See, Pepperidge Farm, Inc.*, 17, BNA OSHC 1993, 1997 CCH OSHD ¶ 31,301; *citing, Miniature Nut and Screw Corp.* 17 BNA OSHC 1557, 1996 CCH OSHD ¶ 30,986 (No. 93-2535, 1996).

Complainant's departure from grouping similar violations results in an aggregate penalty that is disproportionate to the violation and overstates its gravity. The record demonstrates that Complainant did not base the gravity of Saw's under-reporting on the severity of the actual unreported injuries, which consist mainly of minor burns, contusions and foreign bodies in the eye. Rather Complainant argues that the gravity of the violation was high because Saw attempted to avoid inspections by falsely reducing its LWDII. However, the record does not clearly establish that Saw would actually have been inspected had it reported all injuries. A review of the safety violations, which, unlike record keeping violations, pose actual safety hazards to affected employees, does not indicate that this employer was attempting to cover up serious safety hazards by deferring OSHA inspections. In fact, for safety violations found at Saw's facility during the July 2000 inspection, OSHA proposed penalties of only $82,000.00, less than 16% of the penalties assessed for the record keeping violations.

In addition, at the hearing Complainant advanced the theory that Saw engaged in a single pattern and practice of willful non-reporting. Complainant argues that having generally established such a pattern, it follows that all

unrecorded and under-recorded violations were willful. Complainant made no attempt to prove that Saw willfully failed to record each individual injury. The evidentiary path chosen by Complainant was considerably less onerous than showing willfulness in each and every instance. While choosing to make a single showing of a pattern and practice of under-reporting, Complainant nevertheless seeks to have each instance of under-reporting assessed individually, as though she had proved that Saw possessed a willful state of mind in each instance.

Taking these factors into account, I find that a more appropriate penalty would be reached by grouping all record keeping instances into a single violation with a single penalty.

While the individual injuries Saw failed to record were not serious, and though Saw did not appear to be shielding a large number of safety violations by under reporting, the gravity of Respondent's under-reporting was nonetheless high. In this case, Saw crossed the line from simple nonreporting to attempting to influence work restrictions ordered by Dr. Davis. Work restrictions not only make an injury reportable, but, more fundamentally, are physician's orders that embody medical treatment, containing orders necessary for the patient's recovery. To urge a physician to limit or refrain from issuing work restrictions interferes with the patient's medical treatment and intrudes on the doctor/patient relationship. Saw, through Gary Jones, attempted to influence medical treatment to shield itself from inspections. I do not find it relevant that Dr. Davis did not yield to Saw's pressure, or that specific employees were not identified. I find that the gravity of this violation is, therefore, high and the statutory maximum penalty of $70,000.00 is appropriate.

ORDER

1. Wilful citation 1, items 1 through 16, alleging violation of § 1904.2(a), are AFFIRMED.

2. Citation 1, item 17, alleging violation of § 1904.2(a), is VACATED.

3. Wilful citation 1, items 18 through 20, alleging violation of § 1904.2(a), are AFFIRMED.

4. Citation 1, item 21, alleging violation of § 1904.2(a), is VACATED.

5. Wilful citation 1, item 22, alleging violation of § 1904.2(a), is AFFIRMED.

6. Citation 1, item 23, alleging violation of § 1904.2(a), is VACATED.

7. Wilful citation 1, items 24 through 26, alleging violation of § 1904.2(a), are AFFIRMED.

8. Citation 1, item 27, alleging violation of § 1904.2(a), is VACATED.

9. Wilful citation 1, item 28, alleging violation of § 1904.2(a), is AFFIRMED.

10. Citation 1, item 29, alleging violation of § 1904.2(a), is VACATED.

11. Wilful citation 1, items 30 through 33, alleging violation of § 1904.2(a), are AFFIRMED.

12. Citation 1, item 34, alleging violation of § 1904.2(a), is VACATED.

13. Wilful citation 1, items 35 through 43, alleging violation of § 1904.2(a), are AFFIRMED.

14. Citation 1, item 44 alleging violation of § 1904.2(a), is VACATED.

15. Wilful citation 1, items 45 through 62, alleging violation of § 1904.2(a), are AFFIRMED.

16. Citation 1, item 63, alleging violation of § 1904.2(a), is VACATED.

17. Wilful citation 1, items 64 through 66, alleging violation of § 1904.2(a), are AFFIRMED.

18. Wilful citation 1, item 67(1) through 67(7) alleging violation of § 1904.2(a), are AFFIRMED.

19. Citation 1, item 67(8), alleging violation of § 1904.2(a), is VACATED.

20. Wilful citation 1, items 67(9) through 67(14), alleging violation of § 1904.2(a), are AFFIRMED.

21. Citation 1, items 67(15) and 67(16) alleging violation of § 1904.2(a), are VACATED.

22. The violations affirmed are combined for purposes of assessing a penalty. A single penalty of $70,000.00 is ASSESSED.

James H. Barkley
Judge, OSHRC
Dated: May 20; 2002

2001 O.S.H.D. (CCH) P 32528

OCCUPATIONAL SAFETY HEALTH
REVIEW COMMISSION
SECRETARY OF LABOR, Complainant
v.
JINDAL UNITED STEEL CORP., and its successors,
Respondent

OSHRC Docket No. 00-2231
FINAL ORDER DATE: February 11, 2002

Appearances:
For the Complainant:
Danielle L. Jaberg, Esq., Erica J. McGuirk, Esq., Susan Meyercord Williams, Esq., Office of the Solicitor, U.S. Department of Labor, Dallas, Texas
For the Respondent:
Thomas H. Wilson, Esq., Merritt B. Chastain, III, Esq., Julie Merten Esq., Vinson & Elkins, LLP, Houston, Texas

Before: Administrative Law Judge: James H. Barkley

DECISION AND ORDER

This proceeding arises under the Occupational Safety and Health Act of 1970 (29 U.S.C. Section 651 et seq.; hereafter called the "Act").

Respondent, Jindal United Steel Corp., (Jindal), at all times relevant to this action maintained a steel manufacturing plant in Baytown, Texas. Respondent admits it is an employer engaged in a business affecting commerce and is subject to the requirements of the Act.

On May 10 through October 19, 2000 the Occupational Safety and Health Administration (OSHA) conducted an inspection of Jindal's Baytown plant. As a result

of that inspection, Jindal was issued citations alleging violations of the Act together with proposed penalties. By filing a timely notice of contest Jindal brought this proceeding before the Occupational Safety and Health Review Commission (Commission).

On August 3, 2001, the parties entered into a partial settlement agreement disposing of "serious" citation 1, in its entirety. On September 7, 2001 the parties submitted an additional agreement, disposing of "willful" citation 2, items 123 through 126. On September 11-13, 2001, a hearing on the matters remaining at issue was held in Beaumont, Texas. At the hearing the parties filed a joint stipulation in which the Secretary agreed to withdraw willful citation 2, items 7, 41, 62, and 88. Willful citation 2, items 1 through 6, 8 through 40, 42 through 61, 63 through 87, and 89 through 122, remain at issue. Each of the remaining items alleges a violation of § 1904.2(a), which requires that employers record occupational injuries and illnesses. Jindal contests the recordability of 24 of the remaining items, as set forth more fully below. Jindal also disputes the Secretary's willful classification and penalties of all items. The parties have submitted briefs on the matters remaining at issue and this case is ready for disposition.

Background

Jindal purchased the subject plate steel manufacturing facility in Baytown, Texas in 1997 from USX (Tr. 46, 267-67, 526). Jindal is located on the same 59 acre tract which houses Saw Pipes USA, Inc. (Saw Pipes); both were part of an older USX steel mill facility (Tr. 583). The old USX plant produced plate steel, which was then rolled into

pipes. When sold, the plant was divided into two operations, Jindal operating the plate mill, and Saw operating the pipe manufacturing division. The two companies share some common ownership; Saw Pipes holds stock in Jindal (Tr. 141, 595). Saw Pipes commenced its operations prior to Jindal's start up (Tr. 123, 265, 562-64).

Craig Wetherington testified that he interviewed for a safety and health position with Jindal on May 4, 1998 (Tr. 51). Wetherington stated that Ms. Lisa White, Jindal's human resources manager, and Gary Jones, the human resources manager for Jindal's sister company, Saw Pipes, conducted his first interview (Tr. 48, 96). He was then interviewed by Doug Gates, Jindal's plant manager, along with Ms. White (Tr. 48-49). Wetherington stated that his position had no formal job description; he was told that, if hired, his job would entail helping the company come into operational status, and dealing with basic daily safety operations (Tr. 50). Wetherington was further told that he would have ""double line, or dotted line responsibility" to both Mr. Jones and Doug Gates (Tr. 49, 66-67, 76, 98-99, 113). According to Wetherington, Jones was the administrator of the safety program for both Jindal and Saw pipes, and was the ""contract holder, or signature party" for both Jindal and Saw pipes' Workers Compensation policies (Tr. 66, 126). Wetherington would be required to seek permission from Mr. Jones before submitting a claim to Workers' Compensation (Tr. 65). Wetherington was hired later the same afternoon, and reported to work on May 5, 1998 (Tr. 51). Upon reporting for work, Wetherington inspected the physical plant, and reviewed Jindal's safety program and manual, as well as the OSHA 200 logs (Tr. 51-52).

Wetherington testified that he responded to employee injuries and accidents as part of his job (Tr. 52). After he

received a report of an accident he would respond to the site to determine whether additional help was needed to respond. The injured employee would then be taken to the first aid, or nurse's, station. If needed the employee could be transferred to the healthcare provider with which Jindal had a contract, or to the local emergency room (Tr. 52-54). When an accident occurred at the plant, the injured employee's supervisor created an accident report, including the name of the affected employee, the date and location of injury, and a cursory description of the incident, and injury (Tr. 56). The accident report was to be turned over to Wetherington, the duty nurse, or to Doug Gates in the daily turn report, no later than first duty day following the accident (Tr. 56; Exh. C-295 through C-331). The nurse on duty also created a chronological list of all visits to the clinic and the care provided (Tr. 58-59; Exh. C-225, C-226).

Wetherington testified that he followed up on injuries. He examined the first aid log from the on-site first aid station weekly, and checked with the affected employee or with the nurse, who received the injured employee's ""return envelope" from the healthcare provider (Tr. 58-60, 77). The return envelope would list prescriptions and/or physical therapy prescribed, and any physical restrictions on the employee's activity (Tr. 58). Wetherington also signed off on medical bills submitted by the healthcare provider for treatment provided to Jindal employees (Tr. 59-64; Exh. C-168 through C-194). In addition, Wetherington stated, he was responsible for submitting Workers' Compensation forms for eligible employees (Tr. 65).

Craig Wetherington testified that during his tenure at Lowry Air Force Base, between 1983 and 1992, he attended a four day seminar covering the OSHA 200 log, and the requirements for OSHA illness and injury record

keeping (Tr. 42-44). Later, while working as a safety and health director at Grant/PrideCo, Wetherington attended a second, week-long course, sponsored by OSHA (Tr. 43). Wetherington was responsible for maintaining the OSHA 200 logs for Grant/PrideCo. for five years, until 1997 (Tr. 44-45). Wetherington testified that he understood OSHA record keeping requirements, and the meaning of the terms "medical treatment," "restrictive work activity," and "lost workdays" as defined by OSHA (Tr. 42-43).

Wetherington testified that he did not fill out the OSHA 200 logs at Jindal in accordance with OSHA recording criteria. Rather, Wetherington stated, he waited to record any injuries until it was determined whether an employee's injury was sufficiently serious to be reported to Workers' Compensation. If the cost of an employee's medical treatment and lost work time was paid out of pocket by Jindal, the Texas Workers' Compensation first report of injury (TWCC 1) was not forwarded to the state. In that case, Wetherington was not to list the injury on the OSHA 200 logs (Tr. 68, 77-80). If, however, the employee faced an extended period of convalescence or surgery, his or her injury would be reported to Workers' Compensation and listed on the OSHA 200 log (Tr. 65, 68). Consequently injuries meeting OSHA recording requirements were deliberately omitted from the logs. Wetherington testified that he filled out both the Workers Compensation forms and the OSHA 200 forms in accordance with instructions provided him by Gary Jones (Tr. 68).

Within several weeks of his hire date, Wetherington testified, he had a conversation with Jones about the way the Worker's Compensation claims were handled, and the resulting discrepancies in the OSHA logs. Wetherington stated that he told Jones he did not believe the 200 log

was being filled out correctly. Jones told Wetherington that he interpreted OSHA regulations differently and that if Wetherington didn't want to record injuries according to his interpretation, Wetherington could find another job (Tr. 69, 555). Wetherington stated that, on several occasions, he spoke to Jones about the recording practices for the OSHA 200 log, but quit asking when he repeatedly got the same answer to his questions (Tr. 73).

Although Jones never directly stated that it was his intent to skew Jindal's accident data, Wetherington believed that Jones was knowledgeable about OSHA reporting requirements, and could not, in good faith, have interpreted those requirements to exclude all injuries not reported to Workers' Compensation.[1] Wetherington believed that Jones' intent was to misrepresent the number of accident's at the plant, in order to obtain favorable insurance premiums for the company (Tr. 109, 115-116). Wetherington also believed that the purpose of the underreporting was to evade inspections by OSHA by reporting a low Lost Worker Day Index [LWDI] (Tr. 109-110).

Wetherington testified that he reported his conversation with Jones to Lisa White and Doug Gates, specifically stating that he would not be following OSHA requirements when filling out the 200 log when following Jones' instructions (Tr. 70-71, 130). He also went to Joe Hayes, a vice president at Jindal, about his concerns on a specific case (Tr. 75, 117). According to Wetherington, Hayes was not interested, and referred him back to Jones (Tr. 75-76).

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[1] Jones was trained as a lawyer, and worked for 19 years in Brown and Root's legal department, where, among his other duties he responded to OSHA complaints (Tr. 555-56).

White and Gates told him that Jones had the final word on both Workers' Compensation issues and on the OSHA reporting requirements (Tr. 70, 104). While Gates wanted Wetherington to comply fully with OSHA requirements, he recognized Jones' authority over safety issues. He recommended that Wetherington obey his supervisor, and "cover" himself by documenting any objections he had to the way the safety program was run (Tr. 71, 119, 130; *see also* testimony of Lisa White, Tr. 160-61, Exh. 292).

On June 24, 1998, Wetherington wrote a memo for the his personnel file (Tr. 71, 73, 130-31; Exh. C-293), stating that he had asked Gary Jones about the company policy not to report injuries for which a first report of injury or illness had been completed (TWCC 1's), either to the state (Texas Worker's Compensation Commission), or to OSHA. The memo goes on to state that Jones told Wetherington "not to worry about it." Wetherington writes that after reaffirming Gary Jones' final authority over safety matters, he decided to record all first aid on the company logs, but to list on the OSHA 200 log only cases for which Workers' Compensation claims are made (Exh. C-293). Wetherington also wrote a letter to Lisa White restating his position and noting that if Gates truly wants full compliance then "we are going to have to go over Gary's head and report all injuries since the first of the year." Wetherington goes on to note "I do not really think any of us can stand that much heat" (Tr. 71, 73; Exh. C-292).

Wetherington testified that, in addition to under-reporting injuries for which claims had not been filed, he also under-reported injuries involving temporary workers. Wetherington testified that Gary Jones specifically told him that injuries suffered by temporary laborers would be reported by the agency through which the laborer was

employed, and that Wetherington was not to report those injuries (Tr. 74). Wetherington testified that he told Jones this did not conform to OSHA reporting guidelines; Jones told him he interpreted the guidelines differently (Tr. 74, 93). As a result, Wetherington did not report any injuries to temporary laborers; he did not do any followup on temporary employees who had been injured (Tr. 81).

Wetherington identified the OSHA Injury and Illness Data Collection Form for 1998, which he completed and signed (Tr. 82; Exh. C-332, *see also*, Exh. C-402). Eight lost work time injuries were listed for thlendar year, which, according to Mr. Wetherington, corresponded to the number he reported on the OSHA 200 form for that year (Tr. 82-83). The 1998 logs entered into evidence actually show 7 lost work time injuries, and three injuries without lost work time (Exh. R-1, C-400).

Lisa White testified that in April 1998 she interviewed with Gary Jones and Dillip Bhargava for a position as Jindal's human resource manager (Tr. 147-49, 205). She believed Bhargava to be the president of Saw pipes and CEO of Jindal. Gary Jones offered her the position, and she accepted on April 21, 1998 (Tr. 147-49; Exh. C-334). White testified that when she was hired, Dillip Bhargava told her that, while she would be working directly under Joe Hayes, a Jindal vice president, she would be reporting through Gary Jones on any matters relating to safety (Tr. 141, 144-46, 186, 209). Ms. White further testified that she did, in fact, report to Jones on compensation claims and EEOC litigation matters throughout her employment (Tr. 150-51, 162, 181, 188). Ms. White testified that Craig Wetherington was hired three for four weeks into her employment with Jindal; prior to that, there was no safety manager on site (Tr. 151). White testified that during

Wetherington's interview, Gary Jones told Wetherington that he, like her, would have dual reporting responsibility to Jones (Tr. 154).

White recalled Wetherington's concern about Jindal not turning over minor injuries, or injuries without lost work time to their insurance carrier, or reporting those claims on the OSHA 200 forms (Tr. 156-57). She stated that he was also concerned that he had been directed not to report injuries involving temporary laborers on the OSHA 200s (Tr. 157). White confirmed that she was present during Wetherington's meeting with Doug Gates, and corroborated Wetherington's version of events (Tr. 160-61, 195-97). White stated that she was familiar with the recording criteria for the OSHA 200 logs (Tr. 137-40), and realized that the injuries Wetherington was concerned about should have been recorded (Tr. 157-58). However, when Wetherington left Jindal, and White took over responsibility for the 200 logs prior to engaging a new safety manager, White followed the practices Wetherington described to her. White intentionally failed to record at least one injury [cited at item 93] she knew to be recordable, because the employee involved was a temporary worker (Tr. 168-71).

Doug Gates, Jindal's plant manager, testified that Gary Jones introduced him to Craig Wetherington in the course of Wetherington's job interview (Tr. 248-49). According to Gates, Jones told him that Wetherington would be working in the plate mill, but be reporting to Jones (Tr. 250-51, 255). Gates testified that Jindal was "fumbling around trying to start our safety program." (Tr. 252). The only direction Gates gave Wetherington was to "establish a safety program and to be in the field and make observations of the people, the equipment, things like that. . . ."

(Tr. 252). Gates confirmed that Wetherington and White came to him with concerns about the way the OSHA logs were being kept. Gates understood that both Wetherington and White felt that they were being asked to keep the logs in a way that did not conform to their training. However, Gates stated, he was unfamiliar with safety and health issues and felt that Wetherington and White should be discussing their problem with Jones, who was their supervisor (Tr. 253-54, 262). Gates testified that he recommended Wetherington make Jones aware of his objections, and let Jones know that he would bear the ultimate responsibility for any problems (Tr. 255).

Gary Jones testified that in July of 1997 he was hired by Saw Pipes to bargain with the United Steelworkers Union (Tr. 556). Jones testified that Jindal began start up operations in late 1997 or early 1998, but denied that he had any role in that process (Tr. 562). Jones then went on to repeatedly contradict this statement. He testified that his supervisor, Mr. Bhargava, appointed him to act as liaison between Saw Pipes and Jindal's security department, which had a crew putting the Jindal facility in order (Tr. 564). Because he was the only human resources person at the facility, he interviewed, negotiated employment terms and hired Lisa White (Tr. 566-67). Jones claimed to have no role in safety and health decisions at either Saw Pipes or Jindal (Tr. 564). However, Jones hired Saw Pipes safety managers, Ronnie Johnson and, later, Robert Murphy (Tr. 557, 560). He interviewed Craig Wetherington, and when Wetherington left Jindal, Lisa White came to Jones to ask if Murphy could fill in as safety manager (Tr. 566-67). He established a clinic for the benefit of both Jindal and Saw Pipes employees, and arranged for its staffing (Tr. 565). Jones understood that Jindal and Saw

Pipes had the same insurance carrier, but stated that he had no role whatsoever in the administration of either Saw Pipes' or Jindal's Workers Compensation program (Tr. 558, 563).

Jones testified that he was not Lisa White or Craig Wetherington's supervisor, and had no authority to fire or discipline either of them (Tr. 579-82). Jones stated he never had any conversations with any of Jindal's management concerning OSHA reporting requirements, or OSHA 200 forms (Tr. 582-83). He maintained he never told Wetherington that he did not have to report on the OSHA 200 log any injury that was not also reported to Workers' Compensation (Tr. 575). He denied telling Wetherington to under report injuries on the OSHA 200 (Tr. 576).

Jones did recall a conversation with Wetherington regarding injuries to temporary laborers. Jones testified that he gave Wetherington his reasoning for not reporting those injuries, stating that Jindal/Saw didn't supervise those laborers, that the laborers viewed the staffing agency, Labor Ready, as their employer, and that the staffing agency told him that they were maintaining an OSHA 200 log on their employees (Tr. 577). Jones, who is also an attorney, testified that he consulted the Blue Book[2] before discussing the issue with Wetherington (Tr. 590-94). Jones maintained he did not know how Wetherington chose to handle those injuries (Tr. 577).

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[2] The "Blue Book," Record keeping Guidelines for Occupational Injuries and Illnesses, 50 Fed. Reg. 29102 (July 17, 1985), is a compilation of interpretations of the types of injuries to be recorded. The interpretation was published following notice and a period for industry comment.

Jones recalled speaking to Lisa White about Saw Pipes' practice of paying claims out of pocket to avoid Worker's Compensation claims (Tr. 577-78). According to Jones, employers in Texas can opt out of Worker's Compensation program, and that there was nothing illicit about paying small claims in-house rather than turning them over to the insurance carrier (Tr. 559). Jones stated that the in house payment of medical, or lost time claims had no relation to whether the underlying injury was reported to OSHA (Tr. 559).

David McIntosh was hired as Jindal's safety manager on November 8, 1999, about a week after first interviewing for the job (Tr. 305). McIntosh testified that he reported to Lisa White, who reported to both Doug Gates and Gary Jones (Tr. 306). McIntosh testified that he discerned his job duties partially from conversations with Lisa White, but mainly from review of Wetherington's files. From those files McIntosh determined that he was responsible for accident prevention (Tr. 313). McIntosh stated that included accident response, and analysis of the on site first aid logs (Tr. 313-16). McIntosh stated that he was never specifically assigned the task of maintaining the OSHA 200 logs or for submitting claims to Workers' Compensation (Tr. 316-17). However, McIntosh testified, he asked Doug Gates for permission to take on Workers' Compensation, as he had prior experience in the area (Tr. 317). McIntosh testified that he was directed to ask Gary Jones if he needed any instruction on which claims were to be submitted; however, he never had any occasion to do so (Tr. 318-19).

At the hearing, McIntosh testified that responsibility for keeping the OSHA 200 log had never been specifically assigned to him (Tr. 325-26, 339, 341-42, 373-75).

McIntosh assumed responsibility for the OSHA 200 logs on his own initiative at the end of 1999 when he became concerned about the approaching deadline for posting the log (Tr. 317). McIntosh knew Wetherington kept the logs when he was the Jindal's safety manager, however, and he knew that no one else was keeping them.(Tr. 332, 334, 338-39). McIntosh completed the 1999 OSHA 200 logs based on information he located from Wetherington's files (Tr. 324-25). In his December 23, 1999 Turn Report, he notes correcting and updating the OSHA 200 log for 1998. He also states: "Did the same thing for 1999, except I still need to update October through December (Exh. C-374). McIntosh's Turn Reports do not mention the OSHA 200 forms again until February, when he discussed purchasing "EZ Track" software to "stay on top of our injuries and illnesses (Exh. C-385), and setting up a data base to record injuries for 2000 (Exh. C-386). McIntosh testified that he posted the 1999 log in February of 2000 (Tr. 324-25). The log, which has eleven entries, was never updated to include any entries from October and November. Only one entry appears for December, from the 24th, the day after McIntosh noted working on the log (Exh. R-2, C-400).

McIntosh testified that, in his opinion, Jindal was under-reporting injuries; he knew there were recordable injuries that should have been, but were not entered on the OSHA 200 form because they were not reported to Worker's Compensation (Tr. 322-24). No Jindal executive ever told him that Jindal's had a policy to under-report injuries to OSHA, however, Lisa White told him that Jindal's policy on completing the OSHA report was to log only those claims turned into Workers' Compensation (Tr. 320-22, 364-65, 386). White also told McIntosh that, in accordance with Gary Jones' instructions, injuries sustained

by temporary laborers were not to be recorded (Tr. 334). McIntosh testified that he told White that he disagreed with the "unwritten" recording policies (Tr. 339-40). Nonetheless, McIntosh admitted that injuries continued to be under-reported during his tenure as safety manager.

McIntosh denied any personal responsibility for the continued under-reporting, insisting that he had not specifically been assigned the job of maintaining the logs. He completed the 2000 OSHA logs, "just to keep us covered in case something like this did happen" (Tr. 328, 332). McIntosh stated that he did attempt to enter all injuries for which Workers' Compensation claims had been filed into the OSHA log. He couldn't be sure he recorded them all, however, because he didn't have access to the insurance information (Tr. 385-89). McIntosh admitted that he was aware of some recordable injuries that he failed to report (Tr. 342, 350, 352, 354, 355). He testified that he did not record such injuries because he "did not have time," "did not get enough information," was kept "busy doing other things," and was never specifically told it was his responsibility (Tr. 343-64). In particular, McIntosh stated, Sandeep Mishra, Jindal's president, assigned him another project, programming each employee's hand print into the hand scanners for time keeping purposes (Tr. 366, 379). He was also assigned ancillary duties "such as getting the truck scale fixed, getting the fence fixed, finding contractors to fix the bathrooms out in the mill" (Tr. 379). McIntosh insisted that he never made a conscious decision not to record an injury, and maintained that he ignored Jindal's unwritten policies (Tr. 373-74). The 2000 log reflects 13 work related injuries through May of that year (Exh. R-3, C-400).

The cited violations of § 1904.2(a) allege that during the relevant periods of 1998, 1999 and the first half of 2000, Jindal failed to record 75%, 86% and 55%, respectively, of all recordable injuries (Tr. 513; Exh. C-406). Jindal admits that 94 of the 118 cited injuries should have been recorded. Of the 24 citations contested by Jindal, eight are vacated, as discussed more fully below; the remaining 16 are affirmed. Taking the vacated items into account, I find that Jindal failed to record 74%, 84% and 53%, of all recordable injuries, for the 1998, 1999, and the first half of 2000. The classification of the violations as willful, and the appropriateness of the penalty are discussed below.

Violations of § 1904.2(a)

As noted above, citation 2, as amended, alleges 117 violations of § 1904.2. Each item reads: 29 CFR 1904.2(a): The log and summary of occupational injuries and illnesses (OSHA Form No. 200 or its equivalent) was not completed in the detail provided in the form and the instructions contained therein:

Section 1904.2(a) provides:

> Each employer shall, except as provided in paragraph (b) of this section, (1) maintain in each establishment a log and summary of all recordable occupational injuries and illnesses for that establishment; and (2) enter each recordable injury and illness on the log and summary as early as practicable, but no later than 6 working days after receiving information that a recordable injury or illness has occurred.

Section 1904.12 states:

> (c) *Recordable occupational injuries or illnesses* are any occupational injuries or illnesses which result in:
>
> (1) Fatalities . . . (2) Lost work day cases, other than fatalities, that result in lost workdays; or (3) Nonfatal cases without lost workdays which result in transfer to another job or termination of employment, or require medical treatment (other than first aid) or involve: loss of consciousness or restriction of work or motion. This category also includes any diagnosed occupational illnesses which are reported to the employer but are not classified as fatalities or lost workday cases.
>
> (d) Medical treatment includes treatment administered by a physician or by registered professional personnel under the standing orders of a physician. Medical treatment does not include first aid treatment even though provided by a physician or registered professional personnel.
>
> (e) First Aid is any one-time treatment, and any followup visit for the purpose of observation, of minor scratches, cuts, burns, splinters, and so forth, which do not ordinarily require medical care. . . .

Citation 2, items 1 through 6 and 8 through 15. Jindal does not contest the underlying violations set forth in items 1 through 15. Those items allege violations resulting from injuries occurring on February 23, March 10, April 26, May 7, June 3, June 9, June 24, August 17, 1998 August 27, August 28, October 15, October 23, November 15, December 4, and December 8, 1998. Jindal admits not only that the injuries occurring on those dates

were recordable, but that Jindal management knew or should have known that (1) the injuries were recordable, and (2) the injuries were not, in fact, recorded.

Citation 2, item 16. Joe Potter, a shift maintenance foreman at Jindal United Steel, testified that he strained a muscle in his lower back while attempting to lift an oil drum (Tr. 438). Potter testified that he was given medications which he was to take for two weeks (Tr. 438). Records from the San Augustine Industrial Clinic support Potter's testimony; the clinical notes indicate that on January 13, 1999, a Dr. Arora suggested the use of a lumbar corset, ordered a course of therapy and prescribed daily doses of 75 mg of Arthrotec (Exh. C-18). Potter was released for work "with the following instructions: . . . *NO EXCESSIVE* . . . LIFTING OVER *25* POUNDS . . . SQUATTING . . . CLIMBING."

Recordability. Jindal maintains that the Secretary failed to prove that Joseph Potter received medical treatment for his injury, in that she failed to prove how many doses of Arthrotec Potter was prescribed, or that Arthrotec is a prescription medication. Jindal further maintains that any restrictions in activity resulting from the injury did not prevent him from performing his normal job duties.

Under Fed. R. Civ. Pro. 201(b)(2), this judge may take notice of facts " "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be question. This judge notes that The Physicians Desk Reference lists Arthrotec as a prescription drug used mainly for treating osteoarthritis. Potter testified that he was to take the medication for two weeks.

OSHA's Record keeping Guidelines for Occupational Injuries and Illnesses (hereafter referred to as the Blue

Book), contains OSHA's official interpretation of the record keeping requirements (Exh. C-403). The Blue Book states, in pertinent part, that medical treatment includes the use of prescription medications (Except a single dose administered on a first visit for minor injury or discomfort) (Exh. C-403, p. 43). Joseph Potter's injury was recordable under the plain meaning of the standard.

Knowledge. Craig Wetherington was provided with a log sheet containing two entries concerning Potter's injury, and a notation that Potter went to San Augustine Clinic (Exh. C-225, p. 12). An injury incident report was prepared, noting that Potter injured his back (Exh. C-307).

Initially, this judge notes that this, and, in fact, **all** of the cited violations were discovered during a review of records obtained, considerably after the fact, in the course of the OSHA investigation. The records reviewed were in Jindal's control or in the control of its agents. Such documents were available for the review of Jindal's safety management at any time. Thus I find that even if Jindal's safety managers lacked specific knowledge of any of the contested injuries, they could, with the exercise of reasonable diligence, have known of the medical treatment provided to the employees named in the citations.

The Secretary has established the cited violation.

Citation 2, item 17. On January 14, 1999 Joe Edwards, a crane electrician, fell approximately six feet from a platform at Jindal's plant (Tr. 442-43). Edwards testified that he went to the clinic, but wouldn't say that he actually hurt his back (Tr. 441). The Accident Report from the San Augustine Industrial Clinic states that Edwards was restricted to ground work only, no climbing, for one week; however, Edwards testified that there was nothing that he

did prior to the accident that he could not do after he fell (Tr. 444; Exh. C-19). Edwards stated that after he returned from the clinic, he went back to work.

Jindal maintains that the injury sustained by Joe Edwards did not result in any restrictions in activity that prevented him from performing his normal job duties. This judge agrees.

Section 1904.12(c)'s relationship to subparagraph (f), is explained in the Blue Book, which discusses restriction of work or motion resulting in lost workdays, stating that:

> *Lost workday cases involving days of restricted work activity* are those cases where, because of injury or illness ... the employee worked at his or her permanently assigned job but could not perform all the duties normally connected with it.
>
> Restricted work activity occurs when the employee, as a result of a job-related injury or illness, is physically or mentally unable to perform *all or any part* of his or her normal assignment during *all or any part* of the workday or shift. The emphasis is on the employee's *inability* to perform normal job duties over a normal work shift. (Exh. 403, p. 48). Edwards testified that he was not injured when he fell on January 14, 1999, and that after visiting the clinic, he returned to his normal work activities. This judge cannot find that Edward's accident was recordable as that term is defined by OSHA's own guidelines.

Item 17 is vacated.

Citation 2, items 18 through 20. These items are uncontested. Jindal admits that it failed to list on its log

and summary of occupational injuries and illnesses (OSHA Form No. 200) recordable injuries suffered by its employees on January 22, January 26, and February 2, 1999.

Citation 2, item 21. On February 3, 1999 Ronnie Lindsey was moving debris with a front end loader, when the wind blew trash into his face. The day following this incident, Lindsey reported to the plant dispensary (Tr. 474-77; Exh. C-212). Lindsey was referred to the OccuCare Industrial Medicine Clinic. His eye was flushed, and a doctor provided Lindsey with a medicated eye patch, which he was to wear for 24 hours (Tr. 475-76; Exh. C-22). Lindsey was released to return to restricted duty on February 4, 1999, with instructions that he was to be released from the restriction, *i.e.* monocular vision, on February 5, 1999, if he experienced no further problems (Exh. C-22). Lindsey testified that he was in charge of the mobile equipment operators, and that his duties included moving heavy equipment (Tr. 476). Lindsey stated that he could not move the equipment with monocular vision (Tr. 477).

Jindal maintains that the injury sustained by Ronnie Lindsey did not result in any restrictions in activity that prevented him from performing his normal job duties.

The evidence establishes that Lindsey was unable to perform part of his normal assignments during his February 4, 1999 shift, the day following the onset of his injury. (Exh. C-403 pp. 48, 51, # 4). According to the guidelines set forth in the Blue Book, Lindsey's injury was recordable. Jindal had constructive knowledge of the violation, as discussed at item 16. The Secretary has established the cited violation.

Citation 2, items 22 through 24. These items are not contested. Jindal admits that it knew, or should have known that on February 10, February 19, and March 6, employees suffered recordable injuries that were not recorded on Jindal's OSHA 200 log.

Citation 2, item 25. On March 12, 1999, Ronnie Lindsey was working with a front end loader when a hydraulic line broke, spraying Lindsey with hot hydraulic fluid (Tr. 477). Lindsey testified that, after a few hours, he developed a rash similar to a severe sunburn on his face, shoulders and chest, which worsened over time (Tr. 476). The nurse at Jindal's onsite dispensary washed the rash down with antibacterial soap, and gave Lindsey some lotion (Tr. 479). Lindsey returned to the dispensary for observation over the next several days before the rash subsided (Tr. 480).

Jindal maintains that the illness suffered by Ronnie Lindsey did not constitute an occupational illness, and was, therefore, not recordable. The Blue Book states that:

> Under the OSH Act all work-related illnesses must be recorded, while only those injuries which require medical treatment (other than first aid), or involve loss of consciousness, restriction of work or motion, or transfer to another job are recordable. The distinction between injuries and illnesses, therefore, has significant recordkeeping implications.

The instructions for distinguishing between injuries and illnesses are form, included in the Blue Book (Exh. C-403, at p. 37)

> [w]hether a case involves an injury or illness is determined by the nature of the original event

> or exposure which caused the case, not by the resulting condition of the affected employee. Injuries are caused by *instantaneous* events in the work environment. Cases resulting from anything other than *instantaneous* events are considered illnesses. . . . A single incident involving an instantaneous exposure to chemicals is classified as in injury. Had Lindsey's rash resulted from a chemical exposure over time, it would certainly have been classified as a recordable occupational illness.[3] Because Lindsey's injury arose out of a single incident, however, it must be classified as an injury. Injuries are only recordable when the criteria set forth in § 1904.12(c) are met, *i.e.*, when the injury requires medical treatment other than first aid, or involves a loss of consciousness, or restriction of work or motion. Because the Secretary has not alleged, or shown, that Lindsey's March 12, 1999 injury involved any of the criteria set forth in § 1904.12(c), this item must be vacated.

Citation 2, item 26. On the morning of April 7, 1999 William Williams reported to Jindal's on site dispensary complaining that he had suffered a contusion to his left knee when he fell down some stairs while carrying a

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[3] An occupational illness " . . . is any abnormal condition or disorder other than one resulting from and occupational injury, caused by exposure to environmental factors associated with employment. It includes acute and chronic illnesses which may be caused by inhalation, absorption, ingestion or direct contact.

* * *

Occupational Skin Diseases or Disorders

Examples: Contact dermatitis, eczema or rash caused by primary irritants and sensitizers or poisonous plants, oil, acne, chrome ulcers, chemical burns or inflammations, etc.

ladder. The nurse had Williams elevate his leg and apply an ice pack for 15 minutes (Exh. C-215; C-225, JUSS 2720). Later in the day Williams returned to the dispensary, complaining of lower back pain; the on site nurse applied a heat pack (Exh. C-215, C-225). On April 8 Williams asked to be referred to a doctor, and was sent to OccuCare Industrial Medicine Clinic, where he was examined. Williams was diagnosed with thoracic strain; his X-rays were negative; no treatment was prescribed. Williams was released for work, with instructions not to perform any excessive lifting (Exh. C-27).

The Secretary maintains that the two injuries were recordable, because they arose out of the same incident, and involved the "[a]pplication of hot or cold compress(es) during second or subsequent visit to medical personnel." Jindal maintains that William Williams was treated with "first aid," and that any restrictions on activity resulting from his injury did not prevent him from performing his normal job duties. Jindal argues that the injury, therefore, was not recordable. This judge agrees.

William Williams suffered two injuries on April 7, 1999. A contusion to his left knee was treated with a single cold compress. During a subsequent visit, Williams complained of a separate injury to his back, which was treated with a single hot compress. Williams was referred to the OccuCare clinic for tests, but received no treatment. Because Williams' bruised knee and strained back muscle are separate injuries, and because Williams received only one treatment for each injury, this judge cannot find the injuries were recordable. Citation 2, item 26 is vacated.

Citation 2, items 27 through 30. are not contested. Those items list two recordable injuries suffered by Jindal

employees on April 21, and one injury on both April 23, April 27, 1999. None of those injuries were recorded on Jindal's OSHA 200 log.

Citation 2, item 31. On April 27, 1999, Alice Carter, formerly Alice Godfrey, was bitten by a brown recluse spider[4] while walking through the "slab yard" at Jindal's facility (Tr. 484). Ms. Carter testified that she notified her foremen, and went to the on site clinic before being referred to a doctor at the OccuCare clinic (Tr. 482; Exh. C-33). Carter was provided with a prescription salve (Ceftin) and antibiotics, which she was to use until gone (Tr. 482; Exh. C-33). Ms. Carter testified that she "was using" the salve, but had an allergic reaction to it (Tr. 482). She returned to the clinic on May 3, 1999 (Tr. 483; Exh. C-33). The doctor prescribed a different medicine, which proved effective (Tr. 482-483). In his May 3, 1999 notes, Dr. Arora states that Carter missed work Saturday and Sunday due to the allergic reaction (Exh. C-33). However, Carter testified at the hearing that she did not miss any work either because of the spider bite, or her allergic reaction to Ceftin (Tr. 483).

Jindal maintains that Carter, was treated with "first aid" only, and that the injury, therefore, was not recordable. Jindal further maintains that Carter's injury did not result in any lost work days.

This judge finds no reason to discount Alice Carter's testimony that she did not lose any work days due to her injury. Dr. Arora's notes are not necessarily contradictory,

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[4] Instructions on the back of the OSHA 200 Log Sheet state that "conditions resulting from animal bites, such as insect or snake bites . . . are considered injuries." (Exh. C-403, p. 64).

as Saturday and Sunday are not regular work days. Nor does this judge have any reason to question Ms. Carter's testimony that she "was using" the Ceftin salve, testimony from which this judge infers Carter was prescribed multiple doses. A work related injury requiring multiple doses of a prescription medication is recordable; *see*, the Blue Book, Exh. 403, p. 43. Jindal had constructive knowledge of the violation, as discussed at item 16. The Secretary has made out the cited violation.

Citation 2, item 32. An April 29, 1999 accident report from OccuCare indicates that, on that date, William Arthur had a dressing applied to a contusion/abrasion (Exh. C-34). Arthur was released for return to work with instructions to avoid "excessive" weight bearing on his right foot (Exh. C-34). Arthur testified that his normal job activities, repairing row lines, require him to bear excessive weight on both feet (Tr. 485-86). However, Arthur could not recall this injury at all (Tr. 485).

Jindal maintains that the injury sustained by William Arthur did not prevent him from performing his normal job duties. Jindal maintains that the injury, therefore, was not recordable.

The work restriction notation in Arthur's accident report in insufficient to show that Arthur was actually unable to perform his normal job duties over a normal work shift as a result of the cited injury. The Secretary failed to carry her burden in this instance, and this item must be vacated.

Citation 2, item 33. Jindal does not contest citation 2, item 33, which alleges that a recordable injury that occurred to J-99-20 on May 13, 1999 was not recorded on the OSHA 200 log. That item will be affirmed.

Citation 2, item 34. Nurses notes dated May 18, 1999 and an accident report from OccuCare dated May 19,1999 indicate that on May 14, of that year, Roger Blunt was cutting steel with a torch when hot slag fell on his boot. The slag burned through his boot, Blunt was diagnosed with first and second degree burns on the instep of his left foot (Exh. C-36, C-222). Jindal's nurse cleaned and dressed the burn with 1% Silvadene creme on May 18, and 19,1999 (Exh. C-222). The Physician's Desk Reference states that Silvadene 1% is a prescription anti-microbial ointment, silver sulfadiazine.

Because Blunt was treated with a prescription medication on his initial *and* on a subsequent visit to Jindal's clinic, the injury should have been recorded in accordance with the instructions provided in the Blue Book.

Jindal had constructive knowledge of the violation, as discussed at item 16. Citation 2, item 34 will be affirmed.

Citation 2, items 35 through 38. Jindal does not contest these items which alleges violations regarding recordable injury that occurred May 18, June 27, July 13, July 15, 1999 was not recorded on the OSHA 200 log. Those items will be affirmed.

Citation 2, item 39. On July 23, 1999, Maria Garcia reported to Jindal's dispensary complaining of pain in her right foot (Exh. C-227). The on-site nurse directed Garcia to wrap and elevate the foot over the weekend, and take 800 mg. of Advil every six hours. Garcia was to return on July 26, 1999 if she had seen no improvement (Exh. C-227). On July 26 Garcia returned, complaining of pain and swelling in the arch of the foot. Craig Wetherington was notified and Garcia was referred to OccuCare (Exh. C-227). The OccuCare accident report states that Garcia fell

off a steel plate, spraining her ankle (Exh. C-41). Doctor's notes accompanying the report indicate that Garcia was given 12 samples of Relafen 500, advised to take the medication as directed, to use ankle support, apply heat, and take Tylenol for pain (Exh. C-41). Relafen (Nabumetone), is a prescription non-steroidal anti-inflammatory (NSAID).

Because Garcia was provided with multiple doses of Relafen, a prescription drug, during her third visit to a health care provider concerning the same injury, that injury should have been recorded in accordance with the instructions provided in the Blue Book. Jindal had constructive knowledge of the violation, as discussed at item 16. Citation 2, item 39 will be affirmed.

Citation 2, item 40. Jindal admits the recordability of the injury cited at citation 2, item 40. The injury cited occurred on August 17, 1999, and that item will be affirmed.

Citation 2, item 42. On August 17, 1999, Rich Moody was bitten by an "asp," a caterpillar-like insect; Moody developed an allergic reaction to the bite (Tr. 451-52). Moody reported to the OccuCare Clinic and received two injections, 50 mg. Benadryl and 60 mg. Kenalog.

Jindal maintains that the injured employee in this case, Rich Moody, was treated with "first aid," and that his injury, therefore, was not recordable. This judge disagrees. Moody received two, *i.e.* multiple, doses of prescription medication. In its brief Jindal states that Benadryl is "arguably and over-the-counter medication." However, in this case, Moody received not an oral over-the-counter form of Benadryl, but injectable Benadryl, which is indicated for the immediate amelioration of allergic reactions

or anaphylaxis as an adjunct to epinephrine. The injection was administered by a health care professional, in conjunction with a second prescription drug, Kenalog. The injury was recordable. Jindal had constructive knowledge of the violation, as discussed at item 16, and item 42 is affirmed.

Citation 2, item 43. On the morning of August 19, 1999, James Sherman was stepping off the "roll grinder" when his right calf muscle began to cramp (Tr. 429). Sherman reported to the dispensary, where the nurse on duty iced down his leg for 20 minutes before referring him to OccuCare (Exh. C-229). At OccuCare, Dr. McShane tentatively diagnosed Sherman with a vessel rupture or muscle tear based on the results of a venous doppler test (Exh. C-434). Sherman believed he received an anti-inflammatory, and medication for pain (Tr. 429). McShane's notes confirm that Sherman received samples of Celebrex and was given Tylenol for pain. Sherman was advised to ice the leg, rest and to return to work the following morning.

Jindal maintains that the Secretary failed to prove that James Sherman suffered a work related injury, or that he received treatment in excess of first aid.

Injuries arising on the employer's premises are presumed to be work related, unless the employer shows that the injury is actually a symptom or result of an earlier non-work related event (Exh. C-403, pp. 32-34). Because Jindal introduced no evidence tending to rebut the presumption, Mr. Sherman's injury is deemed work-related. Sherman received medical treatment, in that he was provided samples (plural) of Celebrex (celecoxib), a prescription non-steroidal anti-inflammatory drug. Sherman's

injury was recordable; Jindal had constructive knowledge of the violation, as discussed at item 16, and its failure to record the injury was a violation of the Act.

Citation 2, item 44. Respondent admits it knew or should have known that the injury cited at citation 2, item 44 should have been recorded. That injury took place on August 27, 1999. Citation 2 item 44 will be affirmed.

Citation 2, item 45. On August 30, 1999, Eddie Dietz was injured when a truck he was a passenger in struck some slabs in Jindal's sled yard (Tr. 435). Dietz testified that he struck the windshield and cut his right forearm (Tr. 433). Dietz was taken to the dispensary, where he was referred by the on-site nurse to OccuCare (Tr. 433; Exh. C-438). Dietz testified that he was given samples of muscle relaxants and antibiotics at the clinic, which he took twice a day for two to three days (Tr. 434). In earlier statements Dietz testified that he was given muscle relaxants for two days, or, pain pills and a packet of four muscle relaxers (Exh. R-29). Dr. McShane's notes from the OccuCare accident report indicate that rather than writing a prescription for Celebrex, Dietz was given samples of the medication.

While Dietz appeared to mistakenly believe that Celebrex, an anti-inflammatory, was a muscle relaxant, he was sure that he took more than one dose of the medication he was provided at the clinic. This judge finds that the cited injury was recordable. Jindal had constructive knowledge of the violation, as discussed at item 16. Item 45 will be affirmed.

Citation 2, item 46. Jindal admits citation 2, item 46, which alleges that a recordable injury that occurred at Jindal's facility on September 30, 1999. That injury was

not recorded on the OSHA 200 log in violation of the Act. Item 46 is affirmed.

Citation 2, item 47. At the hearing Arthur testified that he had gotten metal in his eyes on approximately three different occasions (Tr. 490). Arthur did not recall the dates of each incident, but remembered that on one of these occasions, he was sent to the clinic, where a doctor used a magnetic needle to remove the metal from his eye (Tr. 488). Arthur also recalled being given an eye patch at that time (Tr. 488). Arthur stated that he was going home after visiting the clinic, and so did not miss any work, or worry about the eye patch (Tr. 488).

The documentary evidence establishes that on the afternoon of October 4, 1999, William Arthur reported to the San Augustine Industrial Clinic complaining of foreign bodies in his eye (Exh. C-46; C-232). At the clinic, two foreign bodies were removed from his right eye using an "alger brush." Arthur was given an eye patch medicated with Blephamide cream and released for work. The restriction, ""monocular vision" was noted on his accident report (Exh. C-46). The doctor's notes further reveal that Arthur returned the following day for a follow-up exam. At the follow up, Arthur told the doctor that he removed the patch the preceding night. He complained of a dark discharge from his right eye and of sensitivity to light. A sample of Ciloxan was provided to him (Exh. C-46).

Ciloxan (Ciprofloxacin HC1) Ophthalmic is a synthetic, sterile, multiple dose, antimicrobial for topical ophthalmic use. The recommended dosage regimen is: One or two drops instilled into the affected eye at regular intervals while awake for five to 14 days. As Ciloxan is not a single dose medication, Arthur's treatment cannot be

classified as first aid, and his injury was recordable. Jindal had constructive knowledge of the violation, as discussed at item 16. Item 47 is affirmed.

Citation 2, items 48 through 61 and 63 through 66. These items are not contested. The violations allege that Jindal knew, or should have known that 18 injuries occurring at their facility on October 5, and 27, November 1, 4, 17, 19, and December 2, 4, 6, 13, 15, 28, 1999, and on January 3, 13, 29, February 15, and April 11, 2000 should have been recorded on the OSHA 200 log. Those items will be affirmed.

Citation 2, item 67. On April 13, 2000, William Arthur reported to the on-site dispensary to have his eye checked. Jindal's nurse referred him to Saint Augustine Clinic, where he was diagnosed with a corneal abrasion, given a medicated eye patch, and released for work with a restriction for monocular vision (Exh. C-69).

At the hearing, Arthur could recall being given an eye patch following an eye injury (Tr. 491). Arthur stated that he could not have done his job with monocular vision, because his depth perception would be impaired; however, Arthur stated that he did not miss any time at work because he was injured right before he was to have four or five days off, so that he did not have to take any time off (Tr. 488, 491).

Jindal contests willful citation 2, item 67, maintains that the injuries sustained by William Arthur did not prevent him from performing his normal job duties. This judge agrees. The Blue Book states that a lost time injury, involving either missed or restriction of work, occurs only if the employee would have worked during the period affected by the injury. If the employee was not scheduled

to work during that period, the injury need not be counted as a lost or restricted work time case. Because Arthur testified that he was not scheduled, and therefore did not miss any work due to his injury, that injury was not recordable. Item 67 is vacated.

Citation 2, item 68. Jindal does not contest item 68. It admits that it knew, or should have known that the April 18, 2000 injury alleged there in should have been recorded.

Citation 2, item 69. Roy Bohman testified that on April 27, 2000 he hit his head on a metal plate, sustaining a cut above his ear (Tr. 447, 450). Bohman testified that he was diagnosed with a mild concussion, and given a prescription (Tr. 447). Bohman stated that he had the prescription filled at the hospital, and took the medication for four days (Tr. 447-48). In its brief, Jindal maintains that the notes in Bohman's medical "presumably the physician's handwritten notes," which it provided in response to discovery are illegible (Jindal's Post Hearing Brief, p. 43). However, the notes clearly state that a small laceration to Bohman's left ear was infected; 500 mg. Rocephin, and 500 mg. of Cipro, both of which are prescription broad-spectrum antibiotics, were prescribed. Five days of Cipro were prescribed (Exh. C-71).

The notes corroborate Bohman's testimony that he received medical treatment in the form of multiple doses of prescription medication. The injury should have been recorded. Jindal had constructive knowledge of the violation, as discussed at item 16. Item 69 is affirmed.

Citation 2, item 70. The Secretary introduced injury reports indicating that on November 25, 1998 Brandon Aldridge slipped and cut his left arm while picking up a

piece of metal (Exh. C-289). The record does not reveal whether Aldridge returned to work after his injury; however, on November 30, 1998, Aldridge visited the Baycoast Occupational Medicine Clinic complaining of back pain suffered as a result of the incident (Exh. C-72). The results of Aldridge's back exam were within normal limits (Exh. C-72). Dr. Carl C. Davis recommended daily physical therapy for three days and placed Aldridge on modified duty; Aldridge was not to engage in repetitive lifting of weight over 25 pounds (Exh. C-72). Complainant submitted a November 30, 1998 "transitional duty job offer" from Labor Ready, Aldridge's employer. The job offer states that Aldridge has been released by his medical provider for light duty and offers him an office position for 10 hours a week, at $5.15/hour (Exh. C-289).

Jindal contests citation this item, maintaining that the injuries sustained by Aldridge did not prevent him from performing his normal job duties. Prior to Aldridge's injury he was employed by Jindal as a helper in their sheers department (Exh C-289); after his injury his physician released him for work, with a restriction against the repetitive lifting of 25 pounds. Aldridge did not testify at the hearing, and nothing in the evidence indicates whether Aldridge's job as a helper involved the repetitive lifting of 25 pounds. This judge cannot infer from the physician's report that Aldridge was *unable* to perform all or any part of his normal assignments. Although Labor Ready offered Aldridge a transfer to light duty, nothing in the evidence indicates whether Aldridge needed or accepted that offer. This judge notes that on the same day the offer of transitional employment was made, a Labor Ready representative completed an accident investigation report in which the investigator quoted Aldridge as promising to

"start paying attention to the job (Exh. C-289). This judge declines to infer from Labor Ready's offer of transitional employment that Aldridge was unable to, or even that he did not resume his normal duties at Jindal on December 1, 1998.

The Secretary has failed to carry her burden of proof on this item, and it will be vacated.

Citation 2, items 71 through 77. Jindal admits that it knew, or should have known that the injuries cited at citation 2, items 71 through 77 should have been recorded. The cited injuries, which occurred on March 2, June 3, June 17, June 29, August 12, November 10 and December 3, 1998 were not recorded on the OSHA 200 log as required under the Act, and items 71 through 77 are affirmed.

Citation 2, item 78. Complainant introduced an accident report stating that on April 21, 1998, Theresa Holub strained her right shoulder lifting 50-60 pounds of steel (Exh. C-81). Holub's medical records indicate that on April 24, 1998, she was diagnosed with shoulder strain and given a prescription for Dolobid (Exh. C-82). The Physician's Desk Reference states that Dolobid is a non-steroidal anti-inflammatory drug used to treat mild to moderate pain and relieve the inflammation, swelling, stiffness, and joint pain. The starting dose is 1,000 milligrams, followed by 500 milligrams every 8 to 12 hours, depending on the individual. Dr. John D. Dang released Holub with instructions that she was not repetitively lift 20 pounds (Exh. C-82). Kathy Cowart, the risk manager from Holub's employer, Meador Staffing Service, testified that Holub was placed on light duty for six days (Tr. 410).

This judge finds it more likely than not that the prescription Holub received was for more than one dose. Moreover, the record indicates that she was placed on light duty for six days and did not return to her assigned duties at Jindal as a result. Her injury was recordable. Jindal had constructive knowledge of the violation, as discussed at item 16, and item 78 is affirmed.

Citation 2, item 79. Jindal does not contest item 79. That item alleges that Jindal failed to record a work related injury that occurred on June 8, 1998, though it knew, or should have known that the injury was recordable. Item 79 is affirmed.

Citation 2, item 80. Christopher Soraiz testified that while he worked at Jindal, he dropped a tool onto his right hand, causing it to swell (Tr. 470, 473). Soraiz reported the injury on April 22, 1998 (Exh. C-85). Dr. Louis F. Puig examined Soraiz on April 23, 1998 (Exh. C-86). Puig released Soraiz for restricted work, advising him not to lift over 20 pounds, push or pull over 30 pounds, or repetitively grasp with his right hand (Exh. C-86). Soraiz testified that his job included painting shelves and rearranging tools (Tr. 471). Soraiz testified that his job normally included lifting weights of over 20 pounds and pushing and/or pulling items weighing 30 pounds (Tr. 472). Soraiz is right handed, and could not paint while unable to grasp with his right hand (Tr. 472-73). Soraiz was released from restricted duty on April 28, 1998 (Exh. C-86).

According to Soraiz, the injury to his hand prevented him from performing portions of his normally assigned duties during the time his motion was restricted. Jindal maintains that Soraiz is not a credible witness and argues

that his injury did not prevent him from performing his normal job duties.

This judge finds no reason to discredit Mr. Soraiz's testimony. Such testimony establishes that his injury was recordable due to the restriction of motion which resulted therefrom. Jindal had constructive knowledge of the violation, as discussed at item 16. Item 80 is affirmed.

Citation 2, items 81 through 86. Jindal admits these violations. Items 81 through 86 allege that Jindal failed to record work related injuries which occurred at its plant on February 11, March 14 April 14, May 15, and June 7, 1998 and on September 15, 1999. Because Jindal admits that it knew, or should have known that the cited injuries were recordable, items 81 through 86 are affirmed.

Citation 2, item 87. On July 30, 1999, Shaun Bishop, a precision flame cutter, suffered a burn to his left eye (Tr. 492-93; Exh. C-258). Bishop visited the Baycoast Occupational Medicine Clinic, where he received a prescription for Cortisporin ophthalmic solution, and released for return for limited duty. Bishop was not to perform any duties requiring depth perception, and was to wear dark glasses for three days (Tr. 493-94; Exh. C-100). Bishop testified that he told the physician that there was no way he could do his assigned job with the use of only one eye. Bishop stated that he was told to take three days off work and, if the problem resolved itself, the doctor would release him for work (Tr. 494). On August 5, Bishop returned to Baycoast, and was released from care (Exh. C-100). Bishop testified that he returned to Jindal, but that his depth of field perception was not the same, and that he could no longer cut steel plate within the precise parameters required by the quality control department (Tr. 494).

Bishop testified that he was eventually transferred out of the department (Tr. 494-95).

Jindal contests citation this item, maintaining that the injuries sustained by Bishop did not prevent him from performing his normal job duties, citing a physician's report, which found that the burn to Bishop's eye was completely resolved, and that the eye appeared completely normal. Mr. Bishop worked as a precision steel cutter at Jindal for only one month prior to the time of the accident (Exh. C-258), and the record is silent on Bishop's prior training and/or experience. On the existing record, this judge is unable to determine whether Bishops inability to perform as a precision cutter resulted from the cited injury.

The record does establish, however, that the injury to his eye forced Bishop to take off three days that he would otherwise have worked. As the injury resulted in lost work days, its should have been recorded (*See*, Blue Book, Exh. C-403, pp. 48-49). Jindal had constructive knowledge of the violation, as discussed at item 16. Item 87 is affirmed.

Citation 2, items 89 through 94. Jindal does not contest these items, which refer to work related injuries sustained at the Jindal plant on January 14, February 9, June 11, August 5, September 1, and October 22, 1999. Though Jindal knew, or should have known, that the cited injuries were recordable, they were not recorded in the OSHA 200 log. Items 88 through 94 are affirmed.

Citation 2, item 95. Accident reports indicate that on July 25, 1999, Bernal Hendrickson suffered a laceration to his right knee when it was struck by a metal plate (Exh. C-115, C-265). Medical records indicate that Hendrickson visited the Baycoast Clinic on August 11, 1999, at which

time the cut was found to be infected. The treating physician prescribed Keflex, identified by the Physician's Desk Reference as a cephalosporin antibiotics prescribed for bacterial infections (Exh. C-116). A Labor Ready accident report states that Hendrickson was to take the medication for one week (Exh. C-265).

Because Hendrickson was prescribed multiple doses of a prescription medication,[5] this injury was recordable. Jindal had constructive knowledge of the violation, as discussed at item 16. Item 95 is affirmed.

Citation 2, item 96. Complainant introduced accident reports indicating that on August 24, 1999, Bernal Hendrickson was injured when hot metal slag splashed into his right eye. The documents state that Hendrickson's eye was flushed, but that on August 25, 1999, he visited the Baycoast Clinic, where he was diagnosed with a corneal abrasion and released for modified duty (Exh. C-118, C-266). The medical release states that Hendrickson was restricted from activities requiring depth perception and/or driving of company vehicles (Exh. C-118, p. 1). As a result of the medical restrictions, Hendrickson's employer, Labor Ready offered him transitional, light duty, office work. Hendrickson refused the offer. (Exh. C-117, p. 2). A Baycoast illness activity and instruction sheet states that Hendrickson was released for work, without restrictions, on August 26, 1999 (Exh. C-118, p. 2). A workers

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[5] It is irrelevant whether Hendrickson actually had the prescription filled, or took the medicine prescribed. (*see*; Jindal's Post Hearing Brief, p. 43). The Blue Book focuses on whether the injury was serious enough that medical treatment should have been provided. Therefore, once a prescription is issued medical treatment is deemed to have been provided (Exh. C-403, p. 44; C-405, p. 10/21).

compensation injury report indicates that Hendrickson returned to work on August 26, 1999 (Exh. C-117, p. 1).

Jindal contests citation 2, item 96. Jindal maintains that the injury suffered by Bernal Hendrickson did not prevent him from performing his normal job duties. At the time of his injury Hendrickson's was employed in Jindal's ""flumes" department (Exh C-266, p. 1). The record does not reveal whether Hendrickson returned to work after the incident on August 24. After seeing his physician on August 25, the physician released him for work, with a restriction against work requiring depth perception, or driving of company vehicles. Hendrickson did not testify at the hearing, and nothing in the evidence indicates whether his assigned duties in the flumes department required driving or depth perception. This judge cannot infer from the physician's report that Aldridge was *unable* to perform all or any part of his normal assignments. Although Labor Ready offered Aldridge a transfer to light duty on August 26, Hendrickson turned the offer down, apparently returning to work at Jindal following his physician's removal of any work restrictions.

The Secretary has failed to carry her burden of proof on this item, and it will be vacated.

Citation 2, items 97 through 103. Jindal does not contest these items, which cite Jindal for failing to record injuries that occurred on January 11, February 23, June 25, August 2, August 23, September 17, and December 8, 1999. Because Jindal admits it knew, or should have known the cited items were recordable, items 97 through 103 are affirmed.

Citation 2, item 104. On October 19, 1999, Tempie Mize suffered a contusion to her left wrist after dropping a

pressure hose on it (Exh. C-274). Ms. Mize sought medical attention at the Baycoast Clinic, where she was advised to limit the use of her left hand for four days (Exh. C-134, p. 4). On October 22 Mize returned to Baycoast, where she told medical staff that she had returned to work, and resumed her normal activities, despite their advice to modify her activities (Exh. C-134, p. 2). On that occasion, Mize received instructions to wear a brace or splint on the wrist until 10/25 (Exh. C-134, p. 1). As a result of her physician's recommendations, Mize's employer, Labor Ready offered her a transitional, light duty position. Mize declined the offer (Exh. C-133, p. 2). Workers' compensation documents show no break in Mize's employment (Exh. C-133, p. 1; C-274, p. 3).

Jindal contests citation 2, item 104. Jindal maintains that the injury suffered by Tempie Mize did not prevent her from performing her normal job duties. At the time of her injury Mize's was employed as a laborer, cleaning Jindal's basement (Exh C-274, p. 1). After seeing her physician on October 19, the physician released her for work, with instructions to modify her activity to minimize the use of her left wrist. Mize did not testify at the hearing and nothing in the evidence indicates whether her assigned duties required repetitive, or excessive use of her left wrist. Mize did tell medical personnel that she continued to perform her normal activities after sustaining the injury. Although Labor Ready offered Mize a transfer to light duty on October 22, Mize turned the offer down, apparently returning to work at Jindal. This judge cannot infer from Labor Ready's offer of light duty that Mize was *unable* to perform all or any part of her normal assignments while wearing a brace.

However, Complainant has introduced a February 6, 1998 Compliance Letter, in which the Secretary interpreted medical treatment to include the use of casts, splints and/or orthopedic devices designed to immobilize a body part (Exh. C-405, p. 15). Ms. Mize's injury is recordable because she was ordered by her physician to wear a brace on her left wrist.

Jindal had constructive knowledge of the violation, as discussed at item 16. Item 104 is affirmed.

Citation 2, items 105 through 109. Jindal does not contest these items. Recordable injuries cited therein occurred on February 26, April 14, April 28, September 21, and October 11, 1999. Jindal admits it knew, or should have known that the cited injuries were recordable, and these five violations are affirmed.

Citation 2, item 110. On May 6, 1999, Ocie Woods, millwright helper, was injured when a piece of metal lodged in his left eye (Tr. 423; Exh. C-280). Woods sought medical attention at the Baycoast Clinic, where his eye was flushed with saline solution. Dr. Carl Davis prescribed 2 drops of Cortisporin ophthalmic solution for four days (Exh. C-144). The Physician's Desk Reference states that Cortisporin is a combination of the steroid, hydrocortisone, and two antibiotics. It is a prescription drug used to relieve inflammatory conditions such as irritation, swelling, redness, and general eye discomfort, and to treat superficial bacterial infections of the eye.

Jindal maintains that the injured employee in this case, Ocie Woods, was treated with "first aid," based on his testimony at the hearing, at which time Mr. Woods testified that he believed Dr. Davis gave him Neosporin, a nonprescription antibiotic (Tr. 423). The medical records

clearly that indicate Cortisporin was prescribed. That Mr. Woods recalls a similar sounding and acting medication is not fatal to the Secretary's case. Jindal had constructive knowledge of the violation, as discussed at item 16. Item 110 is affirmed.

Citation 2, items 111 through 113. Jindal admits it knew or should have known that the cited injuries, occurring on January 28, 1999 and July 27, and October 21, 1999 should have been recorded on the OSHA 200 log. These three items will be affirmed.

Citation 2, item 114. On June 24, 1999, Greg Golden, a general laborer at Jindal, dropped a block on his left big toe (Ex. C-281). Golden sought treatment at the Baycoast clinic on the following day, where the treating physician instructed Golden to wear a "wooden shoe" for four days (Exh. C-150, p. 1). On June 28, Golden was released for a "trial of regular activity" (Exh. C-150, p.2).

Jindal maintains that the injury sustained by Greg Golden did not prevent him from performing his normal job duties. There is, in fact, no evidence establishing what Greg Golden's normal job duties consisted of. Complainant argues, however, that in a February 6, 1998 Compliance Letter, the Secretary interpreted medical treatment to include the use of casts, splints and/or orthopedic devices designed to immobilize a body part (Exh. C-405, p. 15). Complainant maintains that Mr. Golden's injury was recordable on that basis alone. There is no evidence in this record indicating that the purpose of a wooden shoe is to immobilize, rather than to merely protect a damaged toe. In the absence of such evidence there is no basis to support this item. Item 114 is vacated.

Citation 2, items 115 through 122. Jindal admits the recordability of these items, which cite injuries sustained at its facility on January 25, January 28, February 9, March 9, March 14, March 18, April 12, and April 22, 2000. Because those items were not recorded on the OSHA 200 log the cited violations will be affirmed.

Willfulness

The Commission has defined a willful violation as one "committed with intentional, knowing or voluntary disregard for the requirements of the Act or with plain indifference to employee safety." *Valdak Corp.*, 17 BNA OSHC 1135, 1136, 1993-95 CCH OSHD ¶ 30,759, p. 42,740 (No. 93-239, 1995), *aff'd*, 73 F.3d 1466 (8th Cir. 1996). A series of disparate violations may be found willful based on evidence that such violations are part of a deliberate pattern, practice, or course of conduct. *See*, *Kaspar Wire Works, Inc.* (*Kaspar*), 18 BNA OSHC 2178, 2000 BNA OSHC ¶ 32,134 (No. 90-2775, 2000), *appeal filed*, No. 00-1392 (D.C. Cir. Sept. 26, 2000). The Secretary need not show that the employer had an evil or malicious motive to show willfulness. "The state of mind required for a willful violation need be only knowing, voluntary, or intentional." *Id.* at 2183-84.

Temporary Laborers/through October 1999. Jindal admits its was its deliberate practice not to record injuries sustained by temporary laborers. It argues that its practice was a good faith misinterpretation of the OSHA guidelines referring to temporary workers, and so cannot, as a matter of law, be found willful. The Blue Book states, in relevant part:

> If [a temporary laborer is] subject to the supervision of the using firm, the temporary help supply service contractor is acting merely as a personnel department for the using firm, and the using firm must keep the records for the personnel supplied by the service. If the temporary workers remain subject primarily to the supervision of the supply service, the records must be kept by the service. In short, the records should usually be kept by the firm responsible for the day-to-day direction of the employee's activities.

Gary Jones testified that, prior to advising Craig Wetherington not to record injuries to temporary laborers, he reviewed Chapter IV of OSHA's Blue Book. He determined Jindal was not responsible for recording any injuries suffered by temporary laborers, because they were employees of the staffing agencies that provided them (Tr. 561-62, 588-90). Jones claimed to believe that, at one time, Labor Ready provided supervision for their own employees. His description of the relationship with Labor Ready was: "We asked for a welder. They sent us a welder. We said: 'Here's where you will be working, here's the welding machine.' And they began to work. . . ." (Tr. 595). Phil Billeaudeau, the branch manager of Labor Ready, the primary personnel agency that supplied temporary labor for both Saw Pipes and Jindal, testified that laborers supplied by Labor Ready worked under Jindal foremen; it was Jindal's responsibility to supervise the workers Labor Ready provided (Tr. 233). Jones also testified that he based

his advice on his belief that Labor Ready was recording the injuries of its own employees (Tr. 590).[6]

Jindal argues that its decision not to record injuries sustained by temporary laborers is not willful as a matter of law, relying on *Froedtert Memorial Lutheran Hospital, Inc.* (*Froedtert*), 1999 WL 503823 (O.S.H.R.C.), in which the judge found that, though deliberately declining to record injuries suffered by temporary employees, the Respondent's occupational health coordinator lacked the requisite "heightened awareness" of the illegality of her actions necessary to support a finding of willfulness.

As a threshold matter this judge notes that *Froedtert* is an unreviewed judge's opinion without precedential value. If *Froedtert* has any legal effect, it is of providing notice to employers that while a temporary laborer performing duties in furtherance of the using employer's regular business under the supervision of the hiring employer, work related injuries and/or illnesses suffered by such temporary laborer must be recorded by the employer on whose premises the injury occurred. *See*; *Corbesco, Inc. v. Dole*, 926 F.2d 422 (5th Cir. 1991). This judge notes that in an earlier case, *Southern Scrap Materials Co., Inc.*

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[6] Phil Billeaudeau confirmed that, for a time Labor Ready did record off-site injuries suffered by its laborers (Tr. 222, 231-32)

Jimmy Cain, of Mega Maintenance, testified that his staffing agency kept OSHA 200 logs tracking injuries to employees supplied to Jindal, though he never communicated that fact to anyone at Jindal (Tr. 289).

Kathleen Cowart, the risk manager at Meador Staffing Services, testified that, although she understood that it was the hiring employer's duty to record injuries and illnesses on its OSHA 200 forms for temporary laborers, Meador kept duplicate logs "just to be safe." (Tr. 412).

(*SSM*), 1997 WL 735352 (O.S.H.R.C.), also cited by Jindal, the judge reached a conclusion nearly identical to that in *Froedtert*. In *SSM* Judge Welch held that the plain wording of the standard focuses on the injuries and illnesses *for the establishment*, and that the purpose of the OSHA 200 log is to identify the types of injuries and the equipment used at the time the injuries occurred. *SSM*, like *Froedtert*, held that the hiring employer was responsible for recording any illnesses or injuries to workers working at its facility, while performing the hiring employer's work. *Id.*

In any event, Jindal's reliance on *Froedtert* is misplaced. Though it is true that a finding of willfulness is not justified where the employer had a good faith opinion that the violative conditions conformed to the requirements of the cited standard, the Commission has held that the test of good faith for these purposes is an objective one. The employer's belief concerning a factual matter, or as here, concerning the interpretation of a standard, must have been reasonable under the circumstances. *Calang Corp.*, 14 BNA OSHC 1789, 1987-90 CCH OSHD ¶ 29,080 (No. 85-319, 1990). It is abundantly clear that Labor Ready, and the other temporary labor contractor with whom Jindal dealt, acted merely as conduit to provide labor for Jindal. Jindal was the firm responsible for the day-to-day direction of the employees' activities. According to the plain language of the Blue Book, Jindal was the firm responsible for keeping the required OSHA injury and illness records. That Labor Ready recorded injuries sustained by the temporary workers it provided does not affect Jindal's duty under the standard. For Jones, who is an attorney, and who worked in the employee relations and compliance department at Brown & Root before

joining Saw Pipes (Tr. 555, 585), to have interpreted the Blue Book in any other way is not only unreasonable, but incredible. The record establishes that Craig Wetherington, who was knowledgeable in safety and health matters, and who was hired to act as Jindal's safety manager, was aware from his hire date that Jindal had a duty to record such injuries. He conveyed this information to Jones, who insisted Wetherington under report injuries or risk losing his job.

Finally, Wetherington, who was ultimately responsible for filling out the OSHA 200 logs through November 1999, admitted that he deliberately, and knowingly, *i.e. willfully*, failed to record injuries involving temporary laborers, in contravention of OSHA injury reporting requirements.

Employee Laborers/through October, 1999. Craig Wetherington also admitted that he deliberately under-reported employee injuries on the OSHA 200 logs for 1998, and 1999. He claimed to be complying with Jindal's reporting policy, a policy that he believed, and I find to have been formulated by Gary Jones. He believed that his mandate was to record on the OSHA 200 logs only cases for which a claim had been filed with Workers' Compensation. Jindal maintains that Gary Jones never devised such a policy. In support of its contention, Jindal points to the absence of a 1:1 relationship between its Worker's Compensation claims and employee injuries reported on the OSHA 200 (Jindal's Post Hearing Brief, p. 5-11). Jindal notes that more than half the injuries on the 200 log were reported to OSHA, but not to Workers' Compensation.

This judge does not find Jindal's argument persuasive. Such mathematic inconsistency does not rebut Wetherington and White's testimony that Jindal intentionally under

reported injury and illness information to OSHA. The Secretary need not prove that the deliberate under reporting actually followed a particular, discernable pattern. *See*, *Kaspar, supra.*

Supervisory Misconduct. The employer is responsible for the willful nature of its supervisors' intentional misconduct to the same extent that the employer is responsible for its supervisors' knowledge of violative conditions. *Tampa Shipyards, Inc.*, 15 BNA OSHC 1533, 1991-93 CCH OSHD ¶ 29,617 (Nos. 86-360, 86-469, 1992). Once the Secretary has made a prima facie showing of willfulness based on the actions of the employer's managerial personnel, the onus is on the employer to rebut that showing by establishing that the failure to the manager to follow proper procedures was unpreventable. In particular, the employer must establish that it had relevant work rules that it adequately communicated and effectively enforced. *See*; *Consolidated Freightways Corp.*, 15 BNA OSHC 1317, 1991-93 CCH OSHD ¶ 29,500 (No. 86-531, 1991). This Jindal has completely failed to do.

In its brief, Jindal points to the testimony of vice president Joe Hayes, and plant manager Doug Gates, in which each state that they would have disciplined the safety managers, had they realized that injuries were not being properly recorded (Tr. 618-19, 271, respectively). However, at the hearing, both Gates and Hayes testified that, though the safety manager ostensibly reported to them, they had no way of knowing whether the records were being properly maintained because they had no expertise in safety and health matters (Tr. 254, 271, 339, 616). According to Hayes, the safety manager had complete control of Jindal's safety effort; it was solely the safety manager's responsibility to keep Jindal in compliance with

OSHA regulations (Tr. 616). That duty was never clearly communicated to Wetherington or McIntosh, however. Wetherington testified that he was never provided with a formal job description; he was only told that he would be dealing with basic safety operations (Tr. 50). McIntosh discerned his job duties mainly from review of Wetherington's files, and specifically denied being assigned responsibility for OSHA compliance (Tr. 316-17, 364). Neither Gates nor Hayes ever monitored either safety manager's performance, or took any affirmative steps to discover whether the safety manager was competently discharging his duties (Tr. 263, 623-24). As conditions stood, Jindal's upper management was completely insulated from any knowledge about the management, or, in this case, the mismanagement of the safety department, unless it was reported to them by the safety manager himself.

And that is exactly what transpired here. The record establishes that Wetherington put both Gates and Hayes on notice that he was recording injuries improperly based on instructions from Gary Jones. Wetherington and White complained to Gates that Wetherington had been instructed to improperly report injuries. Wetherington complained to Hayes about an injury to a temporary employee that he believed should have been reported. Rather than looking into the matter, both Gates and Hayes referred Wetherington back to Jones, the originator of the improper policy. Though Jindal maintains that Jones was a Saw Pipes employee who had no role whatsoever in Jindal's managerial hierarchy, Wetherington, White, Gates and McIntosh unanimously testified that Jones was the final authority in matters relating to Jindal's injury reporting, and acted accordingly. Neither

Jones, nor anyone in Jindal's upper management made any attempt to change the lines of authority.

It is clear from the record that Jindal failed to instruct or monitor its safety manager in any way. Its management completely abrogated its obligation to ensure compliance with OSHA regulations, referring all its safety manager's questions to Gary Jones, an employee of a sister company. Because the failure of Jindal's safety manager to follow proper procedures was not unpreventable, his willful conduct is imputed to Jindal.

Willful items 1 through 6, 8 through 16, 18 through 24, 27 through 31, 33 through 40, and 42 through 46, involving injuries sustained by Jindal employees during Craig Wetherington's tenure, are affirmed.

Items 71 through 87, 89 through 92, 94 and 95, 97 and 98, 100 through 103, 105, 107 through 112 and 114, all of which involve injuries incurred by temporary laborers during Wetherington's tenure, are affirmed as willful violations of the Act.

Items 93, 104, 106 and 113 concern injuries sustained by temporary laborers during October 1999. At that time Jindal had no safety manager. Lisa White testified that she covered the safety manager's position until David McIntosh was hired in November (Tr. 168). White stated that she investigated only one injury during that period (Tr. 168-69). White knew that the injury was recordable under OSHA criteria; however, she did not record the injury because Jindal's policy was not to report injuries sustained by temporary laborers (Tr. 137-40; Exh. C-170). The failure to record is cited at item 93, and was properly classified as willful, for the reasons discussed above.

Items 104, 106 and 113 also involve recordable injuries to temporary laborers that occurred during October 1999. The evidence establishes that it was the accepted practice at Jindal not to conduct follow up on injuries involving temporary workers, because such injuries were never recorded. Because Jindal's established practice was the direct cause of these violations, this judge finds that they were properly classified as willful.

November 1999 through May 2000. Though he was hired as Jindal's safety manager, David McIntosh denied any responsibility for completing OSHA 200 logs. McIntosh did complete them, because he knew the logs were required by law, and because he knew no one else was maintaining them. McIntosh admitted he realized Jindal was under-reporting injuries, but denied that he ever made a conscious decision not to record an otherwise recordable injury.

McIntosh specifically denied deliberately failing to record an injury merely because the injury was suffered by a temporary employee (Tr. 373). Some injuries involving temporary workers do appear on the 2000 OSHA 200 logs beginning in January (Exh. R-3, R-9). After learning that Labor Ready's Phil Billeaudeau told Lisa White in mid to late 1999 that it was Jindal's responsibility to record any injuries incurred on Jindal's property, (Tr. 222, 228), McIntosh told management, in a February 2, 2000 Turn Report, that his research confirmed Jindal's responsibility for recording injuries and illnesses sustained by temporary laborers working at the Jindal plant (Tr. 335; Exh. C-385).

This judge finds McIntosh's testimony that he had no responsibility for the OSHA 200 logs to be disingenuous. McIntosh knew that OSHA required the logs be kept; his

predecessor kept the logs in previous years; he was aware that no one else was responsible for the logs. It is clear that, despite any clear instructions on the issue, McIntosh knew the OSHA 200 logs fell within his responsibilities as safety manager. The evidence demonstrates that he first began keeping the log on December 23, 1999, basing his entries on information compiled by Craig Wetherington. In his turn reports, McIntosh stated his intent to recreate injury and illness information for the period after Wetherington's departure, and to fill in the gaps in the logs at a later date. This he failed to do. Only two injuries were recorded between December 23, 1999 and the following February when the OSHA log seems to have again come to McIntosh's attention. Ten of the 13 injuries recorded for the first half of 2000 were recorded between March 1, and April 21, 2000 (Exh. R-2; C-400). Because of McIntosh's negligent recording practices, approximately half of the injuries occurring on his watch were never reported. McIntosh blames his sporadic reporting on time constraints, and on the failure of supervisory personnel to report injuries to him in a timely manner. McIntosh insists that he never decided not to record an injury sustained by a Jindal employee, and never complied with Jindal's unwritten practice of reducing injury and illness numbers by excluding temporary laborers from the log.

This record paints a picture of a safety manager who was inattentive to the point of being negligent, resulting in the gross under reporting of injuries on the OSHA 200. Because Jindal never monitored McIntosh's performance in any way, it could not expect to discover or to prevent OSHA violations which resulted from his negligence. Jindal is, therefore, responsible for McIntosh's failure to comply with the Act. However, to establish willfulness

under Commission precedent, the Secretary must prove, by a preponderance of the evidence, that McIntosh and/or Jindal were more than negligent. show that McIntosh, and through him, Jindal, had a "heightened awareness" of the illegality of his actions, and that his actions were knowing, voluntary or intentional. This they failed to do.

In *Kaspar*, *supra*, the Commission was able to infer an intent to under-record where only 1 in 8 injuries were recorded for the cited period, resulting in a 4.3% injury rate. The Commission did not base its decision solely on the sheer number of unrecorded cases, however. Rather a comparison of prior years' recording and injury rates convinced the Commission that Kaspar deliberately "'"chose" to change their recording practices. *Id.* at 2182-84. Because logs kept by the same record-keepers showed injury rates of up to 40% in earlier years, the Commission found it incredible that the consistent under-recording for which Kaspar was cited resulted from mere negligence or carelessness. The Commission could reach no other conclusion than that Kaspar's record-keepers knowingly ceased recording injuries during the relevant period. *Id.*

In this case, McIntosh maintains he never chose not to record a given injury; Jindal maintains that the Secretary failed to introduce any evidence establishing that his failure to comply with OSHA regulations was anything more than carelessness. McIntosh was hired by a start up company which never had an effective reporting program in place. McIntosh had been Jindal's safety manager for only seven months when the OSHA investigation began. OSHA had not previously inspected Jindal's injury and illness logs, or otherwise placed McIntosh, or Jindal on notice of specific recording requirements. Because his predecessor had actively engaged in a practice of under-recording OSHA

injury rates, McIntosh inherited a recording system based on deception. McIntosh's belated start at bringing Jindal into compliance with OSHA record keeping requirements in December, 1999, and his abandonment of the logs until the following March, when a spate of entries were made, including injuries sustained by temporary workers, do not suggest an intent not to report. Rather it suggests inattentiveness, negligence, and a lack of urgency in establishing a system under which all injuries and illnesses could be accurately tracked and correctly recorded.

The Secretary has shown that McIntosh knew his predecessor under-reported injuries on OSHA logs. The Secretary has established that Lisa White told McIntosh that Jindal's unwritten policy was to report to OSHA only injuries which were incurred by Jindal employees, and which were also turned over to Workers' Compensation. The Secretary did not show, by a preponderance of the evidence, that McIntosh followed the unwritten policy, or ever deliberately refrained from recording an injury he knew was recordable. McIntosh recorded 47% of recordable injuries for the first half of 2000, up from Wetherington's 16% for the preceding year. McIntosh's included injuries not submitted to Workers' Compensation, as well as injuries sustained by temporary laborers on the OSHA log. These facts, coupled with his denial of wrongdoing, all militate against finding that his under-reporting was intentional, or resulted from his adherence to the unwritten policy.

The Secretary did not carry her burden in establishing that the remaining failures to record were willful. In her complaint, the Secretary alleges, in the alternative, that the record keeping violations are "serious." The Commission, however, has generally classified recordkeeping

violations as other-than-serious. *See*, *Kaspar*, *supra*; *Caterpillar*, 15 BNA OSHC at 2176-78, 1991-93 CCH OSHD at pp. 42,010-12, fn.16. Even though recordkeeping inaccuracies "may affect employees by misleading them about the nature of their working conditions and by withholding information from organizations, other governmental agencies and individuals performing research in the safety and health field. . . ." *Johnson Controls*, 16 BNA OSHC 1048; 1993 CCH OSHD ¶ 30, 018 (No. 90-2179, 1993), there is rarely evidence that such violations give rise to a "substantial probability" of death or serious physical harm as is required under § 17 of the Act. Because Complainant failed to introduce any evidence that the cited recordkeeping violations bore a direct relationship to employee safety at Jindal's work site, items 47 through 66 and 63 through 66, all of which occurred after McIntosh became Jindal's safety director will be affirmed as other-than-serious violations.

Penalties

The Secretary proposed a penalty of $1,062,000 for Jindal's record keeping violations. While the Secretary has often exercised her authority to group related violations and propose a single penalty for a number of related violations, she chose not to do so here. Rather the violations were individually assessed to increase the total penalty. The $1,062,000 proposed penalty is inappropriate regardless of how it was derived.

In determining the penalty amount, the single most important factor is the gravity of the violation. It is clear that the gravity of this group of violations is based on Respondent's deliberate decision to under-report certain

types of injuries, which resulted in a high percentage of unreported injuries (Tr. 537).[7] Because of their importance in monitoring workplace safety and measuring the effectiveness of safety programs, recordkeeping violations play an important part in ensuring the safety of the American workforce. However, in proposing a total recordkeeping penalty of over $1,000,000 the Secretary overstates the gravity of these violations. Even under the Secretary's theory of the case, Respondent reported major injuries to Workers' Compensation as well as to OSHA while only the more marginal, or less serious injuries went unreported. A review of the unreported injuries tends to support this. Moreover, the Secretary did not prove that Jindal's under-reporting actually immunized them from inspection. *See*, Secretary's Post Hearing Brief, p. 40-42, Exh. C-407). At best, had the injuries been properly reported, Jindal would have been placed on a "supplemental" list of employers who might have been targeted for inspection in 2000 had the local OSHA area office found time. *Id.* OSHA's CO admitted that the area office did not perform many programmed inspections, and mainly responded to complaints, injuries and fatalities, and that Houston area office might also schedule a programmed inspection for a business in a hazardous industry, such as Jindal's (Tr. 532-34).

Based on a review of the violations, I cannot find that the deliberate nature of the violations, or the number of

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[7] There was some confusion in the testimony of Ms. Singleton as to whether the gravity of each failure to record was based on the gravity of the underlying injury, or the gravity of the decision to under-report. It is clear from the individual penalties that the gravity of the underlying injury was not considered since 118 injuries were given identical penalties.

violations justifies a penalty in excess of $1,000,000.00. While it is clear that the Secretary may propose cites multiple penalties for separate violations of the record-keeping standard, Commission review of the proposed penalty is *de novo*, and the judge has discretion to assess a single penalty if deemed appropriate. *See*, *Pepperidge Farm, Inc.*, 17, BNA OSHC 1993, 1997 CCH OSHD ¶ 31,301; *citing*, *Miniature Nut and Screw Corp.* 17 BNA OSHC 1557, 1996 CCH OSHD ¶ 30,986 (No. 93-2535, 1996). Taking into account the Jindal's size, over 250 employees, the very low gravity of the violations, and the absence of any evidence of prior OSHA inspections (Tr. 525-526), this judge finds that a penalty of $70,000 is appropriate. To effectuate the penalty, all willful items are grouped under one willful violation and assessed the maximum penalty of $70,000.

With respect to the record keeping items that were found to be other-than-serious rather than willful, the gravity was overstated for the reasons noted above. All non-willful record keeping items will be grouped, and a single penalty of $7,000, the maximum allowed, will be assessed.

Spoliation

Prior to the hearing Complainant moved for a finding that Respondent had spoliated evidence and requested that a negative inference be drawn. In effect, Complainant alleges Respondent intentionally destroyed documents requested during discovery; Complainant asked that record keeping violations she believe would have been established by the missing documents be affirmed. The

motion was denied with leave to raise the matter and present evidence at the hearing.

The case relied upon by Complainant, *Caparotta v. Entergy Corp.* 168 F3d 754, 756 (5th Cir. 1999), requires a finding of bad conduct by the opposing party before an adverse inference can be drawn. Complainant has failed to establish that such documents were purposefully withheld, as opposed to inadvertently misplaced, as Jindal suggests. Having failed to establish bad conduct the motion is denied.

ORDER

1. Willful citation 2, items 1 through 6, alleging violations of 1904.2(a), are AFFIRMED.

2. Willful citation 2, item 7 is WITHDRAWN.

3. Willful citation 2, items 8 through 16 are AFFIRMED.

4. Willful citation 2, item 17, is VACATED.

5. Willful citation 2, items 18 through 24 are AFFIRMED.

6. Willful citation 2, items 25 and 26 are VACATED.

7. Willful citation 2, items 27 through 31 are AFFIRMED.

8. Willful citation 2, item 32, is VACATED.

9. Willful citation 2, items 33 through 40 are AFFIRMED.

10. Willful citation 2, item 41 is WITHDRAWN.

11. Willful citation 2, items 42 through 46 are AFFIRMED.

12. Citation 2, items 47 through 61 are AFFIRMED as "other than serious" violations of the Act.

13. Willful citation 2, item 62 is WITHDRAWN.

14. Citation 2, items 63 through 66, are AFFIRMED as "other than serious" violations of the Act.

15. Willful citation 2, item 67, is VACATED.

16. Willful citation 2, items 68 and 69, are AFFIRMED.

17. Willful citation 2, item 70, is VACATED.

18. Willful citation 2, items 71 through 87, are AFFIRMED.

19. Willful citation 2, item 88 is WITHDRAWN.

20. Willful citation 2, items 89 through 95, are AFFIRMED.

21. Willful citation 2, item 96, is VACATED.

22. Willful citation 2, items 97 and 98 are AFFIRMED.

23. Citation 2, item 99 is AFFIRMED as an "other than serious" violation.

24. Willful citation 2, items 100 through 113, are AFFIRMED.

25. Willful citation 2, item 114, is VACATED.

26. Citation 2, items 115 through 122, are AFFIRMED as "other than serious" violations.

27. A single penalty of $70,000.00 is ASSESSED for all items affirmed as willful.

28. A single penalty of $7,000.00 is ASSESSED for all items affirmed as other-than-serious.

29. The partial Settlement agreement disposing of willful citation 2, items 123, 124, 125, and 126, having been posted, and not objected to, is hereby approved, and incorporated into this order.

James H. Barkley
Judge, OSHRC
January 3, 2002

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 05-61087

ELAINE CHAO, SECRETARY, DEPARTMENT OF LABOR

Petitioner

v.

OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION; SAW PIPES USA INC

Respondents

CONS/W 05-61089

ELAINE CHAO, SECRETARY, DEPARTMENT OF LABOR

Petitioner

v.

JINDAL UNITED STEEL CORP; OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

Respondents

Petitions for Review of an Order of the Occupational Safety & Health Rev. Comm.

ON PETITION FOR REHEARING
AND REHEARING EN BANC

(Filed Apr. 30, 2007)

(Opinion 2/21/07, 5 Cir., ___, ___ F.3d ___)

Before GARZA, DeMOSS, and OWEN, Circuit Judges.

PER CURIAM:

(✓) The Petition for Rehearing is DENIED and no member of this panel nor judge in regular active service on the court having requested that the court be polled on Rehearing En Banc, (FED. R. APP. P. and 5th CIR. R. 35) the Petition for Rehearing En Banc is also DENIED.

( ) The Petition for Rehearing is DENIED and the court having been polled at the request of one of the members of the court and a majority of the judges who are in regular active service and not disqualified not having voted in favor, (FED. R. APP. P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc is also DENIED.

( ) A member of the court in active service having requested a poll on the reconsideration of this cause en banc, and a majority of the judges in active service and not disqualified not having voted in favor, Rehearing En Banc is DENIED.

ENTERED FOR THE COURT:

/s/ Emilio Garza
United States Circuit Judge

U.S. Department of Labor
Occupational Safety & Health Administration

[SEAL] ***www.osha.gov***

Directives

CPL 02-00-080 – CPL 2.80 – Handling of Cases To Be Proposed for Violation-By-Violation Penalties

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← Directives – Table of Contents

• **Record Type:**	Instruction
• **Directive Number:**	CPL 02-00-080
• **Old Directive Number:**	CPL 2.80
• **Title:**	Handling of Cases To Be Proposed for Violation-By-Violation Penalties
• **Information Date:**	10/21/1990

OSHA Instruction CPL 2.80 October 21, 1990 Directorate of Compliance Programs

Subject: Handling of Cases To Be Proposed for Violation-By-Violation Penalties

A. Purpose. This instruction establishes procedures for identifying and handling cases proposed for citation using the additional penalty factor, provided for in the Field Operations Manual (FOM), Chapter VI, B.2.). (4). The procedures set forth in this instruction will be adopted into the FOM.

B. Scope. This instruction applies OSHA-wide.

C. References.

1. OSHA Instruction CPL 2.45B, June 15, 1989, Revised Field Operations Manual (FOM).

2. OSHA Instruction CPL 2-2.38B, August 15, 1988, Inspection Procedures for the Hazard Communication Standard.

3. OSHA Instruction CPL 2-2.46, January 5, 1989, 29 CFR 1913.10(b)(6): Authorization and Procedures for Reviewing Specific Medical Records to Verify Compliance with 29 CFR 1904.

D. Cancellations.

1. Memorandum from John B. Miles, dated November 20, 1986; Subject: Cases proposed for Citation Using Additional Penalty Factor.

2. Memorandum from Leo Carey, dated June 15, 1987; Subject: Procedures for Handling Potentially Extensive Recordkeeping Violations: Additional Guidelines.

E. Action. Regional Administrators and Area Directors shall ensure that the procedures established in this instruction are adhered to in the handling of cases in which the additional penalty factor is proposed.

F. Federal Program Change. This instruction describes a Federal Program Change which affects State programs. Each Regional Administrator shall:

1. Ensure that this change is promptly forwarded to each State designee using a format consistent with the Plan Change Two-way Memorandum in Appendix F, OSHA Instruction STP 2.22A, CH-2.

2. Explain the technical content of this change to the State designee as requested.

3. Advise the State designees that OSHA has determined that the violation-by-violation citation and penalty policy is an integral part of its nation-wide overall compliance strategy and, therefore, States are required to either adopt OSHA's policy or an alternative "at least as effective as" policy for application to the private sector. States may, but are not required to, extend the policy to their public sector programs.

4. Ensure that State designees are asked to acknowledge receipt of this Federal program change in writing to the Regional Administrator as soon as the State's intention is known, but not later than 70 calendar days after the date of issuance (10 days for mailing and 60 days for response). This acknowledgment must include:

a. The State's plan for adopting identical procedures for documenting and reviewing violation-by-violation cases, adapted as appropriate to reference State law, regulations and administrative structure;

b. The State's plan for developing alternative procedures to those in this instruction which are as effective; or

c. The reasons why it is not necessary for the State to adopt the Federal procedures.

5. Ensure that the State designees submit State plan supplements in response to this instruction, which will be incorporated into the OSHA Field Operations Manual with the next FOM change instruction.

While States must adopt this change within six months of issuance, plan change documentation, through State FOM plan change

supplements, is not required to be submitted more than twice a year in response to OSHA's incorporation of Federal program changes in the FOM.

a. If the FOM changes are issued on their next target date (April 1 or October 1), the States shall have 6 months from the change instruction issuance date to submit a plan supplement in response to the FOM change.

b. If an FOM change is not issued within six months of the date of this instruction, the State shall inform the Regional Administrator of its adoption of this change by submitting documentation describing the State's procedures and implementing instructions. This documentation must be submitted by the close of the calendar quarter following the next FOM change target date which affords the State a 6-month period for implementing the change. However, a formal plan supplement will not be required until issuance of the next Federal FOM change.

6. Advise the State designees to notify their Regional Administrators when they plan to issue violation-by-violation citations and penalties. At the State's request, OSHA will provide assistance in reviewing cases involving violation-by-violation citations and penalties. Regional Administrators will coordinate this review. The review of such cases involving recordkeeping violations similarly may be coordinated with the Bureau of Labor Statistics (BLS) through the Regional Administrator.

7. Review policies, instructions and guidelines issued by the State to determine that this change has been communicated to State compliance personnel.

G. Background. Over the past several years, in a limited number of cases OSHA has alleged a separate violation and proposed a separate penalty for each instance of noncompliance with OSHA recordkeeping regulations, with the safety and health standards, and with the General Duty Clause [Section 5(a)(1) of the Occupational Safety and Health Act (the Act)]. The resulting large aggregate penalties are part of a compliance strategy which improves the efficiency and effectiveness of the agency and conserves its limited resources. This instruction is intended to serve as the master document covering the procedures applicable in cases where the violation-by-violation citation and penalty provisions are employed.

1. In the context of the Act, penalties are intended to provide an incentive to employers to prevent safety and health violations in their workplaces and to correct such violations which do exist voluntarily.

2. The Act intends that this incentive be directed not only to an inspected employer but also to any employer who has hazards and violations of standards or regulations.

a. The large proposed penalties that accompany violation-by-violation citations are not, therefore, primarily punitive nor exclusively directed at individual sites or workplaces; they serve a public policy purpose; namely, to increase the impact of OSHA's limited enforcement resources.

b. The criteria contained in this instruction are intended to ensure that when they are proposed, large penalties serve this public purpose.

3. Large proposed penalties result from application of existing FOM penalty calculation guidelines; but, instead of grouping or combining violations for penalty purposes, each instance of noncompliance is considered a separate violation and a penalty applied separately. This procedure is known as the egregious or violation-by-violation penalty procedure.

a. Application of these procedures is appropriate in situations where the violations in question constitute willful violations of OSHA standards or regulations or of the general duty clause of the Act and meet certain criteria to be discussed later in this instruction at N.2.

b. Since large penalties are likely to result in investigation and widespread public attention, review at the Regional and National Offices of OSHA and the Office of the solicitor of Labor (SOL) is currently mandated.

c. In all other respects, such cases are handled in accordance with the FOM.

4. While this practice of citing each violative instance as a separate violation has been utilized by the agency only since 1986, OSHA is authorized to use this approach by the language of the statute, its legislative history, and the agency's historic role as the sole prosecutor of violations occurring under the Act.

5. In these cases, as in all other cases, violation-by-violation citations and penalties are proposed by the Area Director.

H. Guidance.

1. Early Identification of Cases. It is important that the Area Director identify cases which may be appropriate for violation-by-violation treatment as early as possible.

a. Meticulous documentation of evidence for each violation and appropriate involvement of such technical specialists as may be required for investigation is essential to the successful pursuit of potential egregious cases.

b. Coordination with the Regional and the National Offices must be scheduled in time for comprehensive review before the expiration of the statutory 6-month citation period.

c. Early involvement of the Regional solicitor's office will ensure adequate legal, evidentiary, and resource coordination.

2. Criteria. In general, this instruction identifies those conditions which normally constitute a flagrant violation of the Act or OSHA standards or regulations such that violation-by-violation handling is appropriate.

a. The criteria given in the following section shall be used by the Area Director to determine whether to recommend the use of violation-by-violation citations and penalties.

b. Cases under consideration for such treatment must be classified as willful (category (1) below) as well as at least one of the categories given in (2) through (7).

(1) The employer is found in violation of an OSHA requirement:

(a) Of which she/he has actual knowledge at the time of the violation. Such knowledge may be demonstrated through previous citation history, accident experience, widely publicized agency enforcement, direct evidence of specific recognized jobsite hazards or other appropriate factors; and

(b) Intentionally, through conscious, voluntary action or inaction, having made no reasonable effort to eliminate the known violation.

(2) The violations resulted in worker fatalities, a worksite catastrophe, or a large number of injuries or illnesses.

(3) The violations resulted in persistently high rates of worker injuries or illnesses.

(4) The employer has an extensive history of prior violations of the Act.

(5) The employer has intentionally disregarded its safety and health responsibilities.

(6) The employer's conduct taken as a whole amounts to clear bad faith in the

performance of his/her duties under the Act.

(7) The employer has committed a large number of violations so as to undermine significantly the effectiveness of any safety and health program that might be in place.

3. Penalty Calculation. Penalties for safety and health violations are to be calculated in accordance with the gravity-based penalty procedures in Chapter VI of the FOM. (Since egregious cases involve willful violations, the procedures of B.7.a. generally apply except as noted below.)

a. A separate gravity-based penalty shall be calculated for each violation.

(1) In calculating penalties for each violation, the particular factors associated with that discrete violation shall be used conservatively to calculate a gravity-based penalty; e.g., the number of workers exposed will be low since each violation is to be penalized separately.

(2) The adjustment factor for size shall be applied, if applicable. Factors for good faith and history will normally not be applied.

b. The following additional guidelines are provided to assist in calculating penalties for recordkeeping or similar violations:

NOTE: Only the current and the two previous calendar years are subject to the violation-by-violation penalty procedures in the case of recordkeeping violations (unless the company entered a corporate-wide settlement agreement on recordkeeping) The

Regional Administrator may further limit the scope based on resource availability.

(1) How many violations are involved and how extensive is the problem?

(a) Where the total number of violations is less than 20% of the total number of OSHA-200 log entries for the year, assign a numerical weight of 1 "for number of employees exposed."

(b) Where the total number of violations exceeds 20% but is not more than 50%, assign a numerical weight of 2 for "number of employees exposed."

(c) Where the total number of violations exceeds 50%, assign a numerical weight of 3 for the "number of employees exposed."

(2) How many of the violations were unreported or misrecorded?

(a) If the violation results because a record required to be kept was not made, assign a numerical weight of 3 under "frequency of exposure."

(b) If the violation resulted because a required record was improperly kept, assign a numerical weight of 1 to 3, under "frequency of exposure," depending on the significance of the violation.

1 For example, if an injury was recorded as an injury without lost workdays when it actually did result in lost workdays, assign a 3.

2 If, on the other hand, an injury was correctly recorded as a lost workday case but the number of days was incorrectly recorded, assign a 1.

(3) Did the recordkeeping violation relate directly to the safety and health conditions in the plant? Assign a numerical weight of between 1 and 3 under "employee proximity", depending on the strength of that relationship.

(4) The following two factors shall be averaged and the result (rounded down to the nearest whole number) entered under "stress."

(a) How much does the lost workday injury (LWDI) rate change if the unrecorded cases are included in a recalculation?

1 If the rate doubles (or more) upon recalculation, assign a weight of 3.

2 If, upon recalculation, the rate does not double, assign a weight of 1.

(b) Were the unrecorded injuries serious, investigated by the company, o the subject of workers' compensation claims?

1 If the majority were of a serious nature, or the subject of workers' compensation claims, and not thoroughly investigated by the company, assign a numerical weight of 3.

2 If a minority of injuries were of a serious nature, the company did investigate, and workers' compensation was not heavily involved, assign a weight of 1.

(5) The following factors shall be averaged and the result (rounded down to nearest whole number) entered under "other factors."

(a) What is the character of the company's safety and health history? Does the company's program include training, given to employees and supervisors, regarding compliance with the regulations?

1 Assign a rating of 3 if over all history is weak and training is lacking.

2 Assign a rating of 1 if some evidence exists of training; and the company's history does not reveal a pattern of disregard for safety and health.

(b) Any other significant factors relevant to the violation shall be considered and assigned a value of 1 to 3 depending on their impact on the flagrancy of the violation.

NOTE: No severity factor shall be used in recordkeeping violations.

(6) Following evaluation of the above-mentioned items, an average value or weight of all the factors shall be calculated and rounded down to the nearest whole

number, thereby providing the gravity-based penalty to be used in the violation-by-violation penalty calculation.

c. Guidance on penalty calculation for violations of the hazard communication standard is provided in the FOM, Chapter IV, and in OSHA Instruction CPL 2-2.38B.

d. What will constitute separate violations for purposes of applying the violation-by-violation penalty procedures will depend on several factors.

(1) In cases involving violations of OSHA standards, the standard language must support citation of separate violations. For example:

(a) 29 CFR 1926.21(b)(2) is a requirement for the employer to train each employee in safety and health. For each employee not so trained there is a separate violation of the standard.

(b) 29 CFR 1910.217(c)(1)(i) is a requirement for a point of operation guard for a mechanical power press. Consequently, each mechanical power press unguarded point of operation found is a separate violation of the standard.

(c) 29 CFR 1910.1000(a)(2) limits the exposure of each employee to air contaminants regulated in Table Z-1-A. Thus each employee exposed above the 8-hour time weighted average for a regulated substance constitutes a separate violation of the standard.

(d) 29 CFR 1910.1000(e) requires the implementation of engineering and work practice controls to reduce employee exposure to air contaminants.

With respect to engineering controls, a separate set of controls must be installed at each identifiable source of air contamination. Thus a separate violation exists for each identifiable source of air contamination to which engineering controls have not been applied irrespective of the number of employees overexposed.

NOTE: Since overexposures and engineering controls are two separate violation types, a violation-by-violation citation and penalty may be issued for each.

(2) Substantially similar violative conditions cannot be penalized on a violation-by-violation basis under two different standards. For example:

(a) 29 CFR 1910.1001(c) prohibits exposure of any employee to airborne concentration of asbestos in excess of 0.2 fibers per cubic centimeter of air (8 hr TWA). Hence each employee overexposed constitutes a separate violation.

(b) 29 CFR 1910.1001(g)(1) requires employers to provide respirators to employees overexposed to asbestos and to ensure their use whenever they are required; e.g., in cases where airborne concentrations of asbestos exceed the PEL.

1 Employees without respirator protection have already been cited for overexposure under 29 CFR 1910.1001(c).

2 Respirators are required for that very reason. Thus violation-by-violation penalties for each overexposed employee would be tantamount to a second penalty for substantially the same violative condition and would be inappropriate.

(c) 29 CFR 1910.1001(g)(2) requires that the employer select the appropriate respirator according to Table 1. For the same reason as given in subparagraph (b) 1 above, respirators with the incorrect filters cannot be penalized using violation-by-violation penalty procedures when airborne concentrations exceed the PEL.

(d) When airborne concentrations exceed 50 x PEL and only half-mask respirators are used, the violation is no longer substantially similar and each such respirator may be penalized as a separate violation when provided to an exposed employee for respiratory protection.

(3) Violations of the general duty clause [Section 5(a)(1) of the Act], if egregious, are to be cited in accordance with the FOM, Chapter IV, A.2.

(a) The hazard must be identified with specificity. Multiple citations may not

be issued on the basis of missing controls or different sources or causes of the hazard.

(b) Each employee exposed to the recognized hazard at the time of the violation constitutes a separate violation.

e. All violations not recommended for consideration as egregious shall be classified and issued separately in accordance with the FOM, Chapter V. They shall not be grouped with violations recommended as egregious.

4. Case Support Requirements. Because these cases involve administrative and legal issues critical to the effective enforcement of the Act, it is essential to ensure that the highest professional standards are met in the conduct of inspections, the issuance of citations, and the prosecution of litigation in such cases.

a. Documentation. Whenever a case is proposed for violation-by-violation treatment, as fully detailed responses to the questions listed in Appendix A of this instruction as possible must be developed in writing. Supporting documentation shall be provided and cross-referenced whenever possible.

(1) These questions, originally developed for recordkeeping cases, have been adapted as appropriate for safety and health cases.

(2) Mandatory use of these questions is intended to provide a consistent format to aid in review of these cases, as well as to ensure as far as possible uniformity of case development across Regions.

b. Evidence. Documentary support shall ordinarily be planned for and obtained early in the investigation.

(1) The evidence necessary to support citations being considered for violation-by-violation penalty sanctions shall be included in the case file. Such evidence must be present for each separate violation.

(a) Photographs, videotapes, audiotapes, sampling data, and witness statements shall be used whenever possible to provide supporting evidence of violative conditions.

(b) Company documents supporting knowledge of the standard and the violative conditions as well as willfulness of the violation shall be diligently sought and obtained by subpoena as appropriate.

(c) Examples of such documents are internal audit reports, consultant or insurance company reports, trade association articles, minutes from safety meetings, complaints from employees, memoranda and other correspondence from safety personnel, especially from plant safety to plant management or corporate safety recognizing violations and bringing them to the attention of higher management, and notes relating to OSHA activities and industry practice in other companies or industries.

(2) Employers must be asked explicitly:

(a) If and when they recognized the hazardous nature of each of the violations;

(b) If they knew what OSHA's standards require, and, if so, what steps the company had taken to abate and why the apparent violations had not been corrected;

(c) If they knew of the documents identified under subparagraph (1) above and what those documents contained.

(3) Their responses shall be carefully documented in writing (verbatim if possible). An attempt shall be made to have a second person present as a witness, particularly when dealing with potentially compromising matters.

(4) Signed employee statements shall be obtained routinely to support each of these violations in as much detail as possible.

(5) Employee exposure and the nature and extent of injuries or illnesses related to the violations shall be carefully and adequately described.

(6) The need for subpoenas and medical access orders shall be decided and documents obtained as soon as possible.

(7) The need for experts shall also be decided and necessary arrangements made early. It is anticipated that experts will be needed for cases involving complex violations, such as ergonomics, or abatement methods.

(8) Particular attention shall be paid to anticipating and preparing for possible employer defenses, in accordance with the FOM, Chapter V, E.

c. Early involvement of the Regional Solicitor is essential to examine and evaluate the documentation and other evidence supporting the violations and to determine whether expert witnesses or depositions will be necessary, as well as to provide sufficient time for the Regional Solicitor to write a legal opinion on the merits of the case.

(1) The Area Director (through the Regional Administrator) shall seek legal guidance (informally) from the Regional Solicitor periodically throughout the case development process.

(2) The Regional Administrator shall ensure that such involvement is accomplished at least 4 full months prior to the 6-month issuance date.

(3) The Regional Administrator shall also ensure that the entire case file, including OSHA-1Bs, documentary evidence, statements, and photographs, is made available to the Regional Solicitor 8 weeks prior to the 6-month date.

5. Citations. The Act authorizes penalties to be proposed for each violation but limits the maximum penalty that can be proposed. In accordance with the FOM, Chapter V, the following procedures shall be adhered to in issuing citations with violation-by-violation penalties:

a. Each separate violation must have its own Standard Alleged Violation Element (SAVE). (The SAVE must be repeated for each violation instance.)

b. Each separate violation must have its own Alleged Violation Description which will describe the particular conditions associated with that violation instance.

c. Each separate violation must have its own penalty calculated in accordance with the procedures given in H.3. of this instruction.

6. Regional and National Office Review. The procedures and timetables given below are to be followed in all cases involving violation-by-violation citations.

a. Documentary Package. It is the responsibility of the Area Director to provide adequate documentation of cases involving violation-by-violation citations.

(1) Two copies of the documentation package for all violation-by-violation citations shall be forwarded to the Regional Administrator for review.

(2) The package submitted for review shall include, at a minimum:

(a) A briefing memorandum summarizing the information obtained under H.4. of this instruction.

(b) Copies of all OSHA 1-Bs related to the violations to be proposed for egregious penalty handling. (See NOTE at the end of subparagraph (4) below.)

(c) Copies of all critical evidence establishing the willfulness of the violations.

(d) Copies of all critical evidence establishing the justification for violation-by-violation citation and penalty.

(e) Copies of samples of each type of violation in the proposed violation-by-violation citations.

(3) If the Regional Administrator, after review of the case file material, believes that the case is appropriate for violation-by-violation citation procedures, a copy of the complete documentation package shall be forwarded to the Regional Solicitor as soon as practicable after completion of the review (but no later than 8 weeks before the citation issuance date) for legal analysis and composition of a legal opinion.

(4) The Regional Administrator shall include a copy of the written legal opinion with the documentation package and submit the complete package to the Directorate of Compliance Programs (DCP) as soon as possible after receipt of the legal opinion.

NOTE: It will not be necessary to include copies of all OSHA-1Bs for recordkeeping cases within the documentation package forwarded to DCP. (See H.6.b.(1) of this instruction.)

(5) If the legal opinion has not been received within 5 weeks of the 6-month date, the documentation package shall nevertheless be

submitted to DCP and the legal opinion forwarded as soon as it is received.

(6) The Regional Administrator shall also be responsible for composing a 1- or 2-page summary of the most cogent reasons supporting the egregiousness of the violation and the appropriateness of the application of the additional penalty factor. The summary shall include the following:

(a) Outline of the facts of the inspection, including inspection type, company name and size, operation involved and employee representative, if any.

(b) OSHA inspection history (nationwide and at this plant).

(c) Brief summary of violations found, the number and nature of proposed citations and the amount of the proposed penalty.

(d) Brief justification of willfulness and egregiousness.

(e) Novel issues involved in the case or issues with national implication for program or litigation policy.

(7) The Regional Administrator shall ensure that copies of the summary and the complete documentation package are provided to the Director of Compliance Programs and the National Office of the Solicitor.

b. Recordkeeping Violations. If the case involves recordkeeping violations which are

being considered for additional penalties, two further steps are necessary.

(1) The Area Director shall provide an additional (third) copy of the documentary package (See H.6.a.) to the Regional Administrator which will be forwarded to the National Office for review. This extra copy will be used by BLS for its review and must include all OSHA-1Bs related to proposed egregious recordkeeping violations.

(2) Copies of evidence supporting each recordkeeping violation proposed as egregious, as developed from the company's occupational injury and illness logs and supplementary records, workers' compensation records, medical records, first aid logs and other sources, shall be included in the package. (See Appendix B.)

(3) This evidence must support the existence of a violation for both nonrecorded and misrecorded cases. It must include the particular recordability criteria involved: whether the case involved days away from work and/or days of restricted work activity beyond the day of injury or onset of illness as well as evidence that the case was work related.

> NOTE: Medical records contained in the case file shall be handled in accordance with OSHA Instruction CPL 2-2.46, K.2.

c. Timetable. It is critical to the development of a uniform national policy that all cases appropriate for violation-by-violation citation be handled as such. Regional Administrators and

Area Directors shall adhere as closely as possible to the timetables described below.

(1) Failure to supply the required documentation by the times designated in the following subsections may preclude issuance of violation-by-violation citations in otherwise appropriate cases.

(2) Regional Administrators and Area Directors shall take care not to expand the inspection beyond what they can reasonably expect to accomplish within these time frames.

(3) Within one month after the start of an inspection which appears to be appropriate for consideration for violation-by-violation citation:

(a) The Area Director shall notify the Regional Administrator of a potential egregious case. The Regional Administrator in turn shall notify the Director of Compliance Programs (Attention: Director, Office of General Industry Compliance Assistance, FTS 523-8041) of the following:

1 Establishment name.

2 Area Office of jurisdiction.

3 Six month date.

4 Opening conference date.

5 General type of apparent violations (e.g., safety, health, recordkeeping).

(b) The Regional Administrator shall notify the Regional Solicitor of the impending case and seek advice as to necessary documentation and involvement of outside experts.

(4) The Regional Administrator shall establish an appropriate timetable for periodic submission of the case by the Area Director for Regional Office and Regional Solicitor review.

(a) After 60 days onsite, the Area Director shall ensure that the case is submitted to the Regional Office for information.

(b) The Regional Administrator shall submit the case to the Regional Solicitor for an interim legal review, evaluation and guidance.

(c) As the case is being developed and as additional information becomes available, the Regional Administrator shall ensure that this information is submitted to the Regional Solicitor for additional evaluation.

(5) No later than 8 weeks before the 6-month date, the entire case file shall be submitted to the Regional Solicitor for final legal analysis and for a written legal opinion as outlined in H.4.c.(3).

(6) At the same time, a copy of the complete briefing package and relevant portions of the case file as described in K.6.a. and b. shall be submitted to the Director of Compliance Programs.

(7) No later than 15 days before the 6-month issuance date, at a time to be scheduled by the Director of Compliance Programs, the Regional Administrator shall send appropriate field compliance staff (including the compliance officer(s) conducting the inspection) to the National Office to discuss the proposed citations in detail.

d. National Office Review. Upon receipt of the documentary package, the Director of General Industry Compliance Assistance shall distribute copies to the reviewers.

(1) Copies shall be provided within 2 working days of receipt to the appropriate DCP Compliance Assistance Office, the Office of Field Programs and SOL. The Office of Information and Consumer Affairs shall also be notified.

(2) At the same time a financial profile of the firm shall be requested from the Directorate of Policy, Office of Data Analyses.

(3) Within 10 days of receipt of the documentary package, a National Office technical and legal review shall have been conducted. Following completion of that review, any identified problems or deficiencies shall be conveyed in writing as soon as practicable, but no later than 2 days after the review, to the Regional Administrator for response.

(4) After obtaining any needed additional information, a screening session shall be scheduled with the Deputy Assistant Secretary for presentation of the case. Such

screening shall be scheduled no later than 2 weeks before the 6-month issuance date.

(a) Prior to presentation of the case to the Assistant Secretary or the Deputy Assistant Secretary, the case shall be prescreened by the Director of Compliance Programs and the Associate Solicitor of Labor.

(b) If the case is judged egregious as a result of the prescreening, the case shall normally be presented to the Assistant Secretary or the Deputy Assistant Secretary by the Director of Compliance Programs.

(c) The Regional Administrator shall be prepared to present the facts and other evidentiary details of the case.

(d) The Regional Solicitor will be prepared to discuss the potential litigation aspects of the case.

e. The Assistant Secretary or the Deputy will render a decision on the merits of the case and will give appropriate instructions on how the case is to be handled. Such instructions will address the final penalty amount to be proposed, the date of citation issuance, the coordination of any press releases, and the like.

f. Within 48 hours after issuance, the Area Director shall send a copy of the citation to the Director of Compliance Programs; electronic transmission is acceptable.

I. Delegation of Authority. It is agency policy eventually to delegate authority for decisions regarding the use of the violation-by-violation citation and penalty procedures to the Regional Administrator. The actual delegation of this authority will be addressed in future changes to this instruction.

Gerard F. Scannell Assistant Secretary

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[Appendices Omitted In Printing]